FAQS ON REVISED MEDICARE DRUG ADMINISTRATION CODES AND CANCER CARE DEMONSTRATION PROJECT*

DRUG ADMINISTRATION CODES

1. How do the new Medicare drug administration codes and payments for 2005 compare to 2004?

Attachment A to this FAQ includes a detailed summary of the new codes and crosswalks to 2004 CPT codes.

2. Can you provide an example of how to report chemotherapy using the new G codes?

Example of Coding for Chemotherapy and Related Services			
Service	**Time**	**Codes**	**Explanation**
Hydration (saline)	9:00 to 9:30 (30 minutes)	G0346-59	The hydration service is reported using "each additional" hydration code. *The initial hour of hydration is not used because hydration does not accurately describe the key service performed.* The –59 modifier is used to indicate that hydration is performed prior to the chemotherapy infusion (if performed concurrently, then it would not be separately billable).
Antiemetic (anti-nausea)	9:30 to 10:10 (40 minutes)	G0349	A first antiemetic is infused prior to the chemotherapy; therefore, it is reported using an "additional sequential" therapeutic/diagnostic code.
Chemotherapy (first drug)	10:10 to 11:10 (1 hour)	G0359	Chemotherapy infusion best describes the key service performed; therefore, the first drug and first hour of service is reported using the initial hour of service.
Chemotherapy (second drug)	11:10 to 12:45 (1 hr & 35 minutes)	G0362 & G0360	The second chemotherapy drug is reported as an "additional sequential" infusion. An additional hour of chemotherapy infusion is also used to report the remaining 35 minute infusion of the same drug.
Antiemetic (for diarrhea)	12:45 to 1:00 (15 minutes)	G0349	The second antiemetic was infused sequential to chemotherapy, therefore, it is reported as another "additional sequential" therapeutic/diagnostic infusion code.

* CMS is still in the process of developing guidance for physicians using the new drug administration and cancer care demonstration project codes. CMS has advised that the final CMS guidance may differ slightly from the instructions in this document.

Coding Summary for Above Example

G0359 – initial hour of chemotherapy
G0362 – administration of each additional drug, up to one hour
G0360 – each additional hour of chemotherapy
G0346 – each additional hour of hydration
G0349 (x 2) - administration of each additionally infused drug
J-codes for the saline, antiemetics, and chemotherapy drugs
Any E&M service provided (other than a level one)

3. What does the term "initial" in the new codes refer to?

The term "initial" is now included in the codes because Medicare will provide separate payments for each drug administered on the same day. The term "initial" refers to the first code within a family of codes (e.g., hydration, non-chemotherapy drug administration, chemotherapy administration). At any given patient encounter, only one "initial" code should be billed. When multiple drugs or other agents are administered, the "additional sequential" codes should be used. It may be appropriate in some circumstances for the "initial" code to be a chemotherapy code and the "additional sequential" code to be a non-chemotherapy code.

According to CMS, "the initial code that best describes the service should always be billed irrespective of the order in which the infusions occur." In other words, if you perform hydration and chemotherapy infusion on the same day and the chemotherapy infusion is the key service, it should be billed as the "initial" code even though the hydration might have been performed prior to the chemotherapy infusion.

4. How are the "each additional hour" and the "additional sequential drug" codes different?

Several codes have been added for "additional sequential drugs." These codes are intended to recognize the additional work and practice expense associated with the provision of multiple drugs. The "initial" code therefore refers to the first drug or agent administered and the "additional sequential drug" codes should be used for each drug provided after the first. Therefore, if you administer 3 agents, you should report one "initial" code and two "additional sequential drug" codes. The "each additional hour" codes should be reported if a particular drug is infused for more than one hour and 30 minutes. See coding example under question 3.

5. Do we need to use the –25 modifier to report evaluation and management visits conducted on the same day as chemotherapy?

CMS continues to require that the –25 modifier be attached to E & M services provided on the same day as chemotherapy. Significant, separately identifiable E & M services will be paid if appropriate documentation (outlined in the 1995 or 1997 E & M guidelines) is provided. Additional documentation beyond what is outlined in the guidelines should not be required by your carrier.

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

No. Under Medicare, a level-one office visit (99211) cannot be billed on the same day as chemotherapy. After CMS adopted this policy for 2004, ASCO requested reconsideration, particularly in instances where the office visit is unrelated to the chemotherapy episode. However, CMS not changed its position. If appropriate documentation can be provided, a higher-level office visit may be billed.

7. I understand that the code changes include clarification of reporting times for infusion codes. Is that true?

Yes. Reporting times for infusion codes have been clarified as follows:

For infusions lasting 30 minutes or less, you should round down. For infusions lasting greater than 30 minutes, you should round up. For example, if you conduct a chemotherapy infusion (for one drug) for 1 hour and 45 minutes, you would bill:

G0359	Chemo IV infusion, initial hour
G0360	Chemo IV infusion, each additional hour

Start the timing over when you switch to a different drug (e.g., another chemotherapy agent or an anti-emetic).

8. If a patient is infused with saline <u>concurrent</u> with infusion of a chemotherapy drug, can the hydration be billed separately?

No. Hydration may be billed separately only if it is given prior to chemotherapy infusion or subsequent to drug infusion. If hydration is provided to facilitate drug delivery, then it is considered incidental to that infusion and is not separately billable.

9. Do we need to use a –59 modifier to report multiple infusion services? E.g., if an antiemetic is provided by infusion prior to the chemotherapy infusion, do we need to add the –59 modifier to the antiemetic administration code?

ASCO's interpretation is that the –59 modifier is not needed to report multiple infusion services since the code descriptors now provide clear differentiation between the first and subsequent drugs.

10. 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.

11. We are pleased to see that CMS will implement a new code for irrigation of an implanted venous access device (port flush). Are there any special rules for billing this code?

Medicare will pay for the new G code for irrigation (G0363) only if it is the sole service being reported on the day of a patient encounter.

12. In the past, CMS has not covered injections when provided on the same day as other services. Has CMS revised its policy on injection payments?

Yes. Effective January 1, 2005, Medicare will now pay separately for non-chemotherapy injections and IV pushes even if another service is billed that day. Therefore, codes G0351-G0354 will be eligible for separate payment.

13. Should we continue to report intramuscular injection of an antibiotic using 90788?

Yes. Medicare will continue to recognize and pay for 90788.

14. Are starting an IV or accessing a port included in the drug administration codes or can these services be billed separately?

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 after infusion, and standard supplies associated with infusions are considered to be included in the service.

15. Has the definition of 90783 (intra-arterial drug administration) changed? Will there be a new G code?

The definition and reporting for 90783 have not changed. CMS has clarified that it will not implement a new G code for intra-arterial drug administration and will be issuing a correction notice to this effect.

16. We have been told that prolonged and critical care service codes can be reported to capture work associated with adverse reaction management in the office? However, when we have tried to bill these codes, they are frequently denied or our carrier requires so much documentation that it is too onerous to bill for the codes. What is ASCO's advice?

ASCO is aware of problems with billing for these services and has urged that CMS a) remind carriers that codes for prolonged and critical care services can be billed in the office setting, b) recognize time spent with the patient (as documented in nursing notes) and a brief description of the problem as sufficient documentation to support billing for critical care services, c) eliminate pre-payment reviews or pre-payment demands for documentation with respect to these services, and d) restrict post-payment audits for these services to situations in which there appears to be a pattern of excessive use.

17. We do not have experience billing prolonged service and critical care codes but believe they may be appropriate in some circumstances. What are some general guidelines for reporting these codes?

Prolonged Service Codes

Medicare covers codes 99354-99355, which are used to identify prolonged physician services based on time. These codes are billed in addition to the appropriate evaluation and management code when the time involved exceeds the typical time of the visit code as defined in CPT. For example, the time associated with a level four office visit is 25 minutes. If a physician spends a total of 60 minutes with a patient, the prolonged service codes could be used to reflect time spent with the patient beyond the first 25 minutes (or beyond the office visit). Codes 99354 & 99355 are used to report face-to-face prolonged services provided in the office setting. Code 99354 is used to capture the first hour and 99355 is used to report each additional 30 minutes. Medicare only covers the use of prolonged service codes when the services are provided face-to-face.

To bill these codes, time with the patient does not have to be continuous and can be rounded up or down. In order to bill for the first hour of prolonged service (code 99354), the physician must have provided at least 30 minutes of face-to-face services. Anything less than 30 minutes is rounded down and not reported. Services for 30 minutes or more are rounded up to one hour.

Subsequent services performed after the first hour are reported in increments of 30 minutes or more using code 99355. Services for 14 minutes or less are not reported and services lasting 15 minutes or more are rounded up to 30 minutes.

Critical Care Services

Codes 99291 & 99292 may be used to report physician time spent with a critically ill patient in the office. Medicare covers these services if they meet the definition of a critical illness or injury - "acutely impairs one or more vital organ systems such that there is a high probability of imminent or life threatening deterioration in the patient's condition." These services require the physician's sole attention (the physician should not provide any other services to another patient during the same time). The codes reflect the physician's services directly related to the patient's care whether those services were face-to-face with the patient or non-face-to-face, e.g., reviewing test results or images.

Similar to the prolonged service codes the time spent performing the critical care services does not have to be continuous and can be rounded up or down. In order to bill for the first hour of critical care service (code 99291), the physician must have provided at least 30 minutes of critical care services. Anything less than 30 minutes is rounded down and not reported. Subsequent services performed after the first hour are reported in increments of 30 minutes or more using code 99292. Documentation should include the time spent with the patient, a description of the critical care services performed and reflect the patients treatment during the critical care service.

18. We were disappointed to learn that CMS is not going to implement a new G code for oncology treatment planning. Can treatment planning services be billed under Medicare?

Physician time spent on treatment planning and management is considered to be captured under the E & M codes. Chemotherapy management cannot be billed separately. Time spent by nursing staff and other health professionals on nutrition counseling, therapy management, and care coordination is also not separately billable. ASCO continues to

advocate for adequate recognition and reimbursement for both physician and non-physician chemotherapy management services.

19. When will the new codes become effective?

The new codes for Medicare will become effective January 1, 2005.

20. Are the new G codes for drug administration available for services provided in the outpatient hospital setting?

No. The new drug administration codes are to be used in the office setting only.

21. Will the new codes be used by Medicaid?

Since many cancer patients are dually eligible under Medicare and Medicaid, ASCO has requested that CMS require all Medicaid plans to implement use of the new codes at the beginning of 2005 to avoid confusion and delay in payment. However, CMS has stated that it does not have the authority to require Medicaid to use the codes due to the decentralized nature of the program.

22. Will the new codes be used by private payors?

Private payors will likely implement code changes on an individual basis. ASCO believes that some private payors may implement all of the new codes, some may implement a portion of the codes (e.g., multiple infusions), and some may continue to use CPT codes.

22. Will the Medicare codes for 2005 mirror the 2005 CPT codes?

No. The changes reflected in the new G codes will not be published as CPT codes until 2006.

23. Where can the new fee schedule payment rates be found?

The fee schedule, including relative values, geographical adjustment factors, and conversion factor is available on the CMS website at www.cms.hhs.gov and will be published in the Federal Register on November 15, 2004. You should check you're your Medicare carrier for the rates that apply specifically to your geographic location.

DEMONSTRATION PROJECT

24. How does the new demonstration project for cancer care work?

CMS is establishing 12 new G codes (see below) that will be designed to assess nausea/vomiting, pain, and fatigue for patients receiving chemotherapy. Providers who report to Medicare on the level of nausea/vomiting, pain, and fatigue experienced by their patients will be eligible for a $130 payment for the day of service. To qualify, these factors must be reported for the day that chemotherapy is provided (by IV push or IV infusion). Providers will be paid $130 only once per patient per day. In addition, you

must report on all three factors in order to be eligible for the demonstration payment. Partial payment will not be made when reporting is made on only one or two factors. These G codes apply only in the context of this Medicare demonstration project and can only be used in conjunction with care for patients with cancer.

PATIENT STATUS FACTORS	G CODE	DESCRIPTION OF ASSESSMENT
Nausea and/or Vomiting	G9021	Chemotherapy assessment for nausea and/or vomiting, patient reported, performed at the time of chemotherapy administration assessment **level one: not at all**
	G9022	Chemotherapy assessment for nausea and/or vomiting, patient reported, performed at the time of chemotherapy administration assessment **level two: a little**
	G9023	Chemotherapy assessment for nausea and/or vomiting, patient reported, performed at the time of chemotherapy administration assessment **level three: quite a bit**
	G9024	Chemotherapy assessment for nausea and/or vomiting, patient reported, performed at the time of chemotherapy administration assessment **level four: very much**
Pain	G9025	Chemotherapy assessment for pain, patient reported, performed at the time of chemotherapy administration assessment **level one: not at all**
	G9026	Chemotherapy assessment for pain, patient reported, performed at the time of chemotherapy administration assessment **level two: a little**
	G9027	Chemotherapy assessment for pain, patient reported, performed at the time of chemotherapy administration assessment **level three; quite a bit**
	G9028	Chemotherapy assessment for pain, patient reported, performed at the time of chemotherapy administration assessment **level four: very much**
Lack of Energy (Fatigue)	G9029	Chemotherapy assessment for lack of energy (fatigue), patient reported, performed at the time of chemotherapy administration assessment **level one: not at all**
	G9030	Chemotherapy assessment for lack of energy (fatigue), patient reported, performed at the time of chemotherapy administration assessment **level two: a little**
	G9031	Chemotherapy assessment for lack of energy (fatigue), patient reported, performed at the time of chemotherapy administration assessment **level three: quite a bit**
	G9032	Chemotherapy assessment for lack of energy (fatigue), patient reported, performed at the time of chemotherapy administration assessment **level four: very much**

25. How do I enroll in the demonstration project?

There is no separate enrollment process for this demonstration. Reporting G codes in each of the three areas (nausea/vomiting, pain, and fatigue) will automatically enroll you in the project.

26. Does a physician have to personally ask the patient about the three factors or can a nurse ask and record the results? If a nurse can ask and record the results, is there any requirement that the physician review, countersign, or do anything else with the recorded assessment?

CMS has clarified that a nurse may conduct the assessment of the three patient status factors and record the results of this assessment in the context of providing an incident-to service. The principal requirement for an incident-to service is that the physician must be present in the office suite. Similarly, the physician (or other non-physician practitioner that can bill these services under the State scope of practice laws) should follow incident-to guidelines for reviewing and signing off on the assessment and other services provided.

27. Does the patient have to be asked to select from the list of the four categories ("not at all," "a little," etc.) or can the physician/nurse ask the patient more generally about nausea/vomiting, pain, and fatigue and translate the patient's response into one of the four categories? If such translation is allowed, does the selection need to be confirmed with the patient or can it just be entered as the assessment?

ASCO is seeking clarification on this issue from CMS and will provide additional information when it becomes available.

28. What is sufficient documentation? Is submission of the appropriate G-codes on the claim form by itself sufficient documentation? Does there have to be an entry in the medical records that repeats the selections ('not at all," "a little," etc.) that appear on the claim? If so, are the selections by themselves sufficient documentation, or is any further explanation required to be documented in the medical records? Does the medical record need to reflect a specific intervention, or is documentation of the inquiry sufficient?

CMS has clarified that participants in the demonstration project do not have to provide additional documentation beyond the G codes for the three patient assessment factors. The G codes are considered the "official" documentation and CMS will be providing guidance to Medicare carriers on this point. Providers may certainly want to document interventions related to theses assessments but such documentation will not be considered as part of the qualifying criteria for the demonstration payment.

CODING AND PAYMENT CHANGES FOR MEDICARE DRUG ADMINISTRATION CODES
(Payment amounts reflect national averages for office-based (non-facility) settings)
*See notes below for more information

2005 Medicare Codes	2005 Code Description	2005 RVUs Work Practice Exp. Malpractice **Total**	2005 Payment Rate (Includes 3% Add-On)	2004 Medicare (CPT) Codes	2004 Code Description	2004 RVUs Work Practice Exp. Malpractice **Total**	2004 Payment Rate (Includes 32% Add-On)
HYDRATION (APPLY TO PRE-PACKAGED FLUID AND ELECTROLYTES, E.G., SALINE)							
G0345	Initial hour of IV hydration, initial, up to 1 hour	0.17 1.42 0.07 **1.66**	$64.80	90780	Initial hour, IV infusion for tx/dx (including saline), up to 1 hour	0.17 2.15 0.07 **2.39**	$117.79
G0346	each additional hour of hydration, up to 8 hours	0.09 0.40 0.04 **.53**	$20.69	90781	each additional hour of IV infusion for tx/dx, up to 8 hours	0.17 0.46 0.04 **0.67**	$33.02
THERAPEUTIC/DIAGNOSTIC DRUG ADMINISTRATION (APPLY TO NON-CHEMOTHERAPY AGENTS)							
G0347	Initial hour of IV infusion, initial tx/dx drug, up to 1 hour	0.21 1.75 0.07 **2.03**	$79.24	90780	Initial hour, IV infusion for tx/dx (including saline), up to 1 hour	0.17 2.15 0.07 **2.39**	$117.79
G0348	each additional hour of tx/dx infusion, up to 8 hours	0.18 0.46 0.04 **0.68**	$26.54	90781	each additional hour of IV infusion for tx/dx, up to 8 hours	0.17 0.46 0.04 **0.67**	$33.02
G0349	administration of each additional sequentially infused tx/dx drug, up to 1 hour	0.19 0.89 0.04 **1.12**	$43.72	N/A	N/A	N/A	N/A
G0350	administration of concurrently infused tx/dx drug	0.17 0.44 0.04 **0.65**	$25.37	N/A	N/A	N/A	N/A
G0351	Injection, single/initial tx/drug, subcutaneous or intramuscular	0.17 0.31 0.01 **0.49**	$19.13	90782	Injection for tx/dx, subcutaneous or intramuscular	0.17 0.32 0.01 **0.50**	$24.64

2005 Medicare Codes	2005 Code Description	2005 RVUs Work Practice Exp. Malpractice **Total**	2005 Payment Rate (Includes 3% Add-On)	2004 Medicare (CPT) Codes	2004 Code Description	2004 RVUs Work Practice Exp. Malpractice **Total**	2004 Payment Rate (Includes 32% Add-On)
G0353	IV push, single/initial tx/dx drug	0.18 1.29 0.04 **1.51**	$58.95	90784	intravenous push for tx/dx	0.17 0.80 0.01 **1.01**	$49.78
G0354	administration of each additional sequentially pushed tx/dx drug	0.10 0.57 0.04 **0.71**	$27.72	N/A	N/A	N/A	N/A
CHEMOTHERAPY DRUG ADMINISTRATION CODES ***(APPLY TO NON-RADIONUCLIDE ANTI-NEOPLASTIC AGENTS, MONOCLONAL ANTIBODIES, AND BIOLOGIC RESPONSE MODIFIERS)***							
G0355	Chemo injection, subcutaneous or intramuscular, non-hormonal agent	0.21 1.14 0.01 **1.36**	$53.09	96400	Chemo injection, subcutaneous or intramuscular	0.17 1.12 0.01 **1.30**	$64.07
G0356	Chemo injection, subcutanoue or intramuscular, hormonal agent	0.19 0.74 0.01 **0.94**	$36.69	96400	Chemo injection, subcutaneous or intramuscular	0.17 1.12 0.01 **1.30**	$64.07
G0357	Chemo IV push, single/initial drug	0.24 2.92 0.06 **3.22**	$125.69	96408	Chemo IV push	0.17 2.91 0.06 **3.14**	$154.76
G0358	administration of each additional sequentially pushed chemo drug	0.20 1.61 0.06 **1.87**	$73.00	96408	administration of each additional pushed chemo drug	0.17 2.91 0.06 **3.14**	$154.76
G0359	Chemo IV infusion, single/initial drug, initial hour	0.28 4.19 0.08 **4.55**	$177.60	96410	Chemo IV infusion, initial hour	0.17 4.16 0.08 **4.41**	$217.35
G0360	each additional hour of chemo infusion (up to 8 hours)	0.19 0.77 0.07 **1.03**	$40.20	96412	each additional hour of chemo infusion (up to 8 hours)	0.17 0.74 0.07 **0.98**	$48.30

2005 Medicare Codes	2005 Code Description	2005 RVUs Work Practice Exp. Malpractice **Total**	2005 Payment Rate (Includes 3% Add-On)	2004 Medicare (CPT) Codes	2004 Code Description	2004 RVUs Work Practice Exp. Malpractice **Total**	2004 Payment Rate (Includes 32% Add-On)
G0361	initiation of prolonged chemo (more than 8 hours)	0.21 4.60 0.08 **4.89**	$190.88	96414	initiation of prolonged chemo (more than 8 hours)	0.17 5.22 0.08 **5.47**	$269.59
G0362	administration of each additional sequentially infused chemo drug, up to 1 hour	0.21 1.94 0.07 **2.22**	$86.65	N/A	N/A	N/A	N/A
96520	Refill/maintenance of portable pump	0.21 3.76 0.06 **4.03**	$157.31	96520	Refill/maintenance of portable pump	0.17 3.94 0.06 **4.17**	$205.52
G0363	Irrigation of implanted venous access device (port flush)	0.04 0.69 0.01 **0.74**	$28.88	N/A	N/A		N/A
96530	Refill/maintenance of implanted pump	.21 2.64 0.06 **2.91**	$113.59	96530	Refill/maintenance of implanted pump	0.17 2.86 0.06 **3.09**	$152.29

Notes:

1. The "average payment" figures assume a wage index of 1.000 – actual payment rates will be affected by the applicable wage index adjustment.
2. Medicare will cover one "initial" code per day. The "initial" code should be the best code to describe the key service and does not need to follow the order in which the infusions occur. "Initial" codes are G0345 (hydration), G0347 (non-chemo tx/dx infusion), G0353 (non-chemo IV push), G0357 (chemo IV push), and G0359 (chemo infusion)
3. Medicare will now pay separately for non-chemotherapy injections and IV pushes even if another service is billed that day. Therefore, G codes G0351-G0354 will be eligible for separate payment.
4. Reporting of code G0357 (chemo IV push, single/initial drug) or G0359 (chemo infusion, initial hour, single/initial drug) is required for encounters to qualify for the $130 demonstration payment. The demonstration payment will be made once per day for treatment of a patient with cancer.
5. Certain drug administration codes do not appear in this table because the codes remain the same and the payment does not change significantly. Those codes include 90788 (injection of antibiotic) and codes for intra-lesional, intra-arterial, and intra-cavitary chemotherapy administration.
6. The code descriptions provided in this table are in some cases different than the exact descriptors of the G codes in the Medicare fee schedule. ASCO has deviated from the official descriptions for some codes in an attempt to provide additional clarity.
7. CMS has stated that codes for the infusion of "additional sequential" drugs (G0349 and G0362) crosswalk to the old codes for "each additional hour" of infusion (90781 and 96412, respectively). For the purposes of evaluating payment changes, ASCO agrees that some of the services that were previously coded under the "each additional hour" codes will be captured by the "additional sequential" codes. However, in terms of describing the service provided, the "additional sequential" codes are new.