Practical Tips

Drug Administration Changes in 2008

The 2008 Current Procedural Terminology (CPT®) manual contains changes in the drug administration codes. These changes will have a minimal impact on oncologists who provide infusion services in an office-based setting; however, for facilities that provide infusion services, the impact will be greater. Refinements to the drug administration codes in 2008 were done to establish a hierarchy when drug administration is performed in the facility (eg, hospital outpatient department) setting, to clarify the reporting of administration services performed by the physician versus the facility, and to define a new class of infusion. Other changes include a revision in the definition of the initial hour of hydration and the addition of a code for sequential pushes of the same drug or substance. This article will explain all these refinements.

New language in the preamble of the “Hydration and Therapeutic, Prophylactic and Diagnostic” section specifically establishes a hierarchy of drug administration when it is being reported in the facility setting. Hospitals and facilities raised concerns regarding their reporting of drug administration services, and based on these concerns, a hierarchy was defined to assist facilities in reporting the services. The CPT manual now clearly acknowledges that chemotherapy administration is the primary service that would be followed by therapeutic and diagnostic services, which would then be followed by hydration administration services. The manual also specifies that infusions are primary to administration by the “push” technique, and “pushes” are primary to injections. It is important to note that the hierarchy of services and the distinction of primary services apply only to drug administration services being provided in the facility setting and not when these services are provided in the office setting.

The 2008 CPT® manual also provides clarification on what entity, the physician or the facility, is to report drug administration services. Language in the preambles of the “Hydration and Therapeutic, Prophylactic and Diagnostic” and “Chemotherapy Administration” sections states that, “These codes are not intended to be reported by the physician in the facility setting.” The facility itself would report drug administration services that were provided in the facility setting. If the services were performed in an office-based setting, then the physician would report the services.

New codes to describe subcutaneous infusions (90769–90771) were created and are published in the 2008

edition. These infusions are considered to be therapeutic, diagnostic, and prophylactic in nature; however, they vary from therapeutic/diagnostic intravenous infusions. Code 90769 is defined as an “initial” service to be used to report the subcutaneous infusion, up to one hour, which includes the establishment of a subcutaneous infusion site or sites and the set-up of a pump. Code 90770 is an add-on code that would be used to report an additional hour (above and beyond the first hour and 30 minutes) of a subcutaneous infusion. Code 90771 is also an add-on code that would be used to report an additional pump set-up with the establishment of new infusion sites. These codes were designed to capture the services of providing subcutaneous infusions of immune globulin and theoretically follow the same design as established drug administration codes.

The original definition of 90760 described the **initial** service of an intravenous hydration infusion of “up to 1 hour.” However, the 2008 CPT® manual revises the definition for 90760 to describe the initial service of an intravenous hydration infusion of “31 minutes to 1 hour.” A parenthetical was also added to specify that a hydration infusion of 30 minutes or less should not be reported. The change in the code definition and the addition of a new parenthetical enforce that initial hydration infusions of 30 minutes or less should not be reported. (Hydration provided as a secondary or subsequent infusion is reportable and those services should be reported using code 90761.)

A new code, 90776, was created for additional intravenous pushes of the same substance or drug. This code was created for facility use only, and a parenthetical note clearly defines that restriction. Code 90776 is an add-on code and cannot be reported by the facility if additional pushes of the same drug are less than 30 minutes apart.

The categories and definitions of the drug administration services should be considered the standard working set of codes; however, additional minor refinements to these codes are quite possible in the future. If you have any questions on these new changes or questions about drug administration coding, please call ASCO’s Coding & Reimbursement Hotline at 703-299-1054 or e-mail: practice@asco.org.

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