Part B Insider (Multispecialty) Coding Alert

CORRECT CODING INITIATIVE: Chemotherapy Edits Revoked Retroactive To April

Use -59 modifier to overturn edits before July 1

If you're billing additional sequential IV pushes with chemotherapy or other drug administration codes, your life just got a lot easier.

The **Centers for Medicare and Medicaid Services** announced it will revoke five controversial edits governing drug administration code G0354 (Each additional sequential intravenous push). The National Correct Coding Initiative (NCCI) version 11.1, implemented April 1, bundled HCPCS code G0354 with five codes:

G0345 (Intravenous infusion, hydration; initial, up to one hour)

G0347 (Intravenous infusion, for therapy/diagnostic; initial, up to one hour)

G0357 (Intravenous, push technique, single or initial substance/drug)

G0359 (Chemotherapy administration, intravenous infusion technique; up to one hour, single or initial substance/drug)

G0361 (Initiation of prolonged chemotherapy infusion...)

But NCCI version 11.2, effective July 1, will delete those edits retroactive to April 1.
Until that change takes effect, you can use the -59 modifier "to indicate that there was a separate sequential infusion of a different drug or the same drug at a different time," CMS says. Or you can just wait until after July 1 to submit claims from May or June, and the carriers won't apply the edits at all.

These edits would have been a real problem had they applied to providers going forward, says **Andrea Peters**, infusion billing manager with **Texas Hematology/Oncology** in Dallas.

"They've cut the reimbursement so much on the drugs, the only way to make money is with the administration," she notes. You're should be able to bill an administration code for each bag you hang and drug you give, so these edits run counter to that philosophy, she adds.

Separately, the **American College of Cardiology**, the **American College of Radiology** and the **Society for Interventional Radiology** are still talking to CMS about edits that bundle diagnostic angiograms and venograms with therapeutic angiograms or venograms (See PBI, Vol. 6, No. 9). CMS wrote back within 60 days, but now the societies are in discussions with CMS, according to SIR Senior Manager for Reimbursement **Dawn Hopkins**.

Aside from bundling the diagnostic and therapeutic scans, which interventional radiologists often perform on the same day, CMS has now instructed providers to use modifier -52 (Reduced services) to overcome these edits.