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Using the New G-codes

by Linda B. Gledhill, MHA

In the final physician rule published in the Federal Register on Nov. 15, 2004, the Centers for Medicare & Medicaid Services (CMS) announced that it would begin using G-codes in 2005 for the administration of chemotherapy, hydration, and administration of supportive care drugs. The G-codes are temporary and will be given CPT codes in 2006.

In addition to the new administration codes, CMS also announced a one-year demonstration project to evaluate the resource consumption associated with evaluation of pain, nausea and vomiting, and fatigue associated with chemotherapy services provided in an office-based practice.

Now that practices have had several months to work with these new codes, here are answers to some commonly asked questions about how to use them.

Q Many times I give patients more than one antiemetic for nausea. Can I charge for more than one infusion?

A: Yes. When a patient receives more than one antiemetic infusion, use G0349. This code is used to report the first hour of a “sequential infusion of a second non-chemotherapy drug.”

Q Which of the hydration codes should be used when I hydrate a patient concurrently with chemotherapy?

A: You can now use the code G0346 for concurrent IV infusion. Use this code with a primary code of G0359.

Q CMS is now paying non-chemotherapy therapeutic injections. If I provide another service on the same day, will these injections be paid or will they be considered to be part of the other service?

A: These services will now be paid

in addition to the other services provided.

Q G0356 is used to bill for antineoplastic hormonal injection therapy. Can you give me an example of which drugs these refer to?

A: In 2005 CMS added two new codes for subcutaneous or intramuscular hormonal and non-hormonal antineoplastic injections. These are G0355 for chemotherapy injection, non-hormonal antineoplastic; and G0356 for hormonal antineoplastic injection. Two of the most frequently used hormonal antineoplastic drugs are leuprolide acetate and goserelin acetate.

Q In order to bill for an E&M code on the same day as chemotherapy, do I need to have a different diagnosis code for the visit?

A: No. The E&M service has to be provided as a significant separately identifiable service and the -25 modifier attached. A different diagnosis code is not required for this visit.

Q Can I bill for flushing a port, G0363, on the days that a patient is receiving chemotherapy?

A: According to CMS, a port flush is a billable service only on the days where no other services are provided.

Q CMS has expanded its list of drugs that can be used with the chemotherapy administration code. One category mentioned is monoclonal antibodies. How can I tell which drugs are considered monoclonal antibodies?

A: Drugs that end in “-mab” are generally included in this category. Examples would include trastuzumab, infliximab, rituximab, gemtuzumab, and alemtuzumab.

Q CMS refers to some of the new G-codes as add-on codes. What does

this mean and how does it work?

A: CMS defines add-on codes as codes that are used in addition to a primary code. CMS will pay for these services only when they are billed along with a primary drug administration code. An example would be G0346, IV infusion, hydration, each additional hour up to 8 hours. This code would not be billed alone but would require G0345, IV infusion, hydration initial hour.

Q I have reviewed the third-quarter drug reimbursement on the CMS web site. Will this reimbursement be the same for all of 2005?

A: No. The new ASP drug payment system is based on quarterly data submitted to CMS by manufacturers. The rates in the physician practice will be adjusted quarterly and may fluctuate.

Q If we do a patient evaluation under the demonstration project and do not complete the section involving pain, can we charge for the assessment of nausea/vomiting and the assessment of fatigue?

A: No. According to CMS, transmittal 12, no payment will be made for the demonstration codes unless all three codes are reported.

Q When we charge for the assessment under the demonstration project, is the patient responsible for a co-payment on the \$130 allowance?

A: Yes, the patient is responsible for a co-payment of 20 percent. In addition, any deductible amounts also apply. ☐

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