CMS Manual System

Pub. 100-04 Medicare Claims Processing

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 573 **Date: JUNE 3, 2005**

CHANGE REQUEST 3848

NOTE: ***Transmittal 566, dated May 20, 2005, is rescinded and replaced with Transmittal 573, dated June 3, 2005. The transmittal page for Transmittal 566 listed incorrect manual sections, which had been updated. The corrected manual sections are sections 230.2.1 and 230.2.2. All other information in the instruction remains the same.***

SUBJECT: **Clarifying Manual Instructions for Coding and Payment for Drug Administration Under the Hospital Outpatient Prospective Payment System (OPPS)**

I. SUMMARY OF CHANGES: This instruction implements revisions to §230 in the Medicare Claims Processing Manual, Pub 100-04, Chapter 4, entitled "Billing and Payment for Drugs and Biologicals".

NEW/REVISED MATERIAL :

EFFECTIVE DATE : January 01, 2005

IMPLEMENTATION DATE : June 01, 2005

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (*N/A if manual not updated.*)
(R = REVISED, N = NEW, D = DELETED) – (*Only One Per Row.*)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	4/Table of Contents
R	4/230/Billing and Payment for Drugs and Drug Administration
R	4/230.1/Coding and Payment for Drugs and Biologicals
N	4/230.1.1/Separately Payable Drugs
N	4/230.1.2/Packaged Drugs
N	4/230.1.3/Pass-Through Drugs
N	4/230.1.4/Non-Pass Through Drugs
N	4/230.2/Coding and Payment for Drug Administration
N	4/230.2.1/General
N	4/230.2.2/Administration of Chemotherapy Drugs by Infusion
N	4/230.2.3/Administration of Chemotherapy Drugs by a Route Other Than

	Infusion
N	4/230.2.4/Administration of Non-Chemotherapy Drugs by Infusion
N	4/230.2.5/Administration of Non-Chemotherapy Drugs by a Route Other Than Infusion
N	4/230.2.6/Use of Modifier 59
N	4/230.2.7/Billing for Infusion Hours

III. FUNDING: No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2005 operating budgets.

IV. ATTACHMENTS:

X	**Business Requirements**
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

***Unless otherwise specified, the effective date is the date of service.**

Attachment - Business Requirements

Pub. 100-04	Transmittal: 573	Date: June 3, 2005	Change Request 3848

NOTE: Transmittal 566, dated May 20, 2005, is rescinded and replaced with Transmittal 573, dated June 3, 2005. The transmittal page for Transmittal 566 listed incorrect manual sections, which had been updated. The correct manual sections are sections 230.2.1 and 230.2.2. All other information in the instruction remains the same.

SUBJECT: Clarifying Manual Instructions for Coding and Payment for Drug Administration Under the Hospital Outpatient Prospective Payment System (OPPS)

I. GENERAL INFORMATION

A. Background:

This instruction implements revisions to §230 in the Medicare Claims Processing Manual, Pub 100-04, Chapter 4, entitled "Billing and Payment for Drugs and Biologicals".

B. Policy:

No changes are made to the underlying policies.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3848.1	Fiscal Intermediaries and RHHIs shall follow the re-organized instructions in Pub. 100-04, Chapter 4, §230. [**Note**: Various sub-sections have been revised and created for this manual update; however, there are no new instructions being communicated with this Change Request.]	X	X							

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers: FISS	MCS	VMS	CWF	Other
	A provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic. Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.									

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: **January 1, 2005** **Implementation Date: June 1, 2005** **Pre-Implementation Contact(s):** Marina Kushnirova, mkushnirova@cms.hhs.gov; Rebecca Kane, rkane@cms.hhs.gov **Post-Implementation Contact(s):** Regional Office	**No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2005 operating budgets.**

*__Unless otherwise specified, the effective date is the date of service.__

Medicare Claims Processing Manual

Chapter 4 - Part B Hospital
(Including Inpatient Hospital Part B and OPPS)

Table of Contents

(Rev.573, 06-03-05)

230 – Billing and Payment for Drugs and Drug Administration

(Rev.573, Issued: 06-03-05, Effective: 01-01-05, Implementation: 06-01-05)

This section provides billing guidance and payment instructions for hospitals when providing drugs and drug administration services in the hospital outpatient department.

230.1 – Coding and Payment for Drugs and Biologicals

(Rev.573, Issued: 06-03-05, Effective: 01-01-05, Implementation: 06-01-05)

This section provides hospitals with coding instructions and payment information for drugs paid under OPPS.

230.1.1- Separately Payable Drugs

(Rev.573, Issued: 06-03-05, Effective: 01-01-05, Implementation: 06-01-05)

Hospitals must report all appropriate HCPCS codes and charges for separately payable drugs in addition to reporting the applicable drug administration codes.

Drugs are to be billed in multiples of the dosage identified by the billing code, and rounded up if necessary.

230.1.2 – Packaged Drugs

(Rev.573, Issued: 06-03-05, Effective: 01-01-05, Implementation: 06-01-05)

CMS requests that hospitals voluntarily report the HCPCS codes and charges for drugs that are packaged into payments for the corresponding drug administration service. Historical hospital cost data may assist with future packaging decisions for such drugs.

230.1.3– Pass-Through Drugs

(Rev.573, Issued: 06-03-05, Effective: 01-01-05, Implementation: 06-01-05)

Section 1833 (t)(6) of the Social Security Act provides for temporary additional or "pass-through" payments for certain drugs, devices, and biological agents that meet identified criteria. Under the statute, transitional pass-through payments can be made for at least 2 years, but no more than 3 years.

230.1.4 – Non Pass-Through Drugs

(Rev.573, Issued: 06-03-05, Effective: 01-01-05, Implementation: 06-01-05)

Drugs, biologicals (including blood and blood products), and radiopharmaceuticals that do not have pass-through status are either packaged into existing Ambulatory Payment Classification (APC) payments for services or receive separate APC payment. To find a listing of HCPCS codes used to bill for drugs and biologicals, reference Addendum B of the OPPS Final Rule (updated annually) or the CMS Web site, http://www.cms.hhs.gov/

230.2 Coding and Payment for Drug Administration

(Rev.573, Issued: 06-03-05, Effective: 01-01-05, Implementation: 06-01-05)

230.2.1 – General

(Rev.573, Issued: 06-03-05, Effective: 01-01-05, Implementation: 06-01-05)

*Effective for services furnished prior to January 1, 2005, drug administration services under the Hospital Outpatient Prospective Payment System (OPPS) were reported using HCPCS alphanumeric codes:Q0081, Infusion therapy other than chemotherapy, per visit; Q0083, Administration of chemotherapy by any route other than infusion, per visit; and Q0084, Administration of chemotherapy by infusion only, per visit) in combination with applicable CPT codes for administration of non-infused, non-chemotherapy drugs. (**Note:** HCPCS code Q0085, administration of anti-neoplastic drugs by both infusion and a route other than infusion, per visit, was discontinued in 2004.)*

*Effective for services furnished on or after January 1, 2005, Q0081, Q0083 and Q0084 will not be used to report drug administration services under the OPPS. Instead, hospitals are to use the corresponding 2005 CPT drug administration codes listed in **Table 1** and **Table 2**.*

Table 1: OPPS Chemotherapy Drug Administration Codes
Crosswalk From Discontinued Q-Codes to CPT Codes for Use in CY 2005

CPT Code	Description	SI	APC	Corresponding HCPCS code	Maximum number of units of the APC OCE will assign without modifier 59	Maximum number of units of the APC OCE will assign with modifier 59
96400	Chemotherapy, sc/im	S	116	Q0083	1	2
96405	Intralesional chemo admin	S	116	Q0083	1	2
96406	Intralesional chemo admin	S	116	Q0083	1	2
96408	Chemotherapy, push technique	S	116	Q0083	1	2
96410	Chemotherapy, infusion method	S	117	Q0084	1	2

CPT Code	Description	SI	APC	Corresponding HCPCS code	Maximum number of units of the APC OCE will assign without modifier 59	Maximum number of units of the APC OCE will assign with modifier 59
96412	Chemo, infuse method add-on	N	--	--	0	0
96414	Chemo, infuse method	S	117	Q0084	1	2
96420	Chemotherapy, push technique	S	116	Q0083	1	2
96422	Chemotherapy, infusion method	S	117	Q0084	1	2
96423	Chemo, infuse method add-on	N	--	--	0	0
96425	Chemotherapy, infusion method	S	117	Q0084	1	2
96440	Chemotherapy, intracavitary	S	116	Q0083	1	2
96445	Chemotherapy, intracavitary	S	116	Q0083	1	2
96450	Chemotherapy, into CNS	S	116	Q0083	1	2
96542	Chemotherapy injection	S	116	Q0083	1	2
96545	Provide chemotherapy agent	N	--	--	0	0
96549	Chemotherapy, unspecified	S	116	Q0083	1	2

Table 2: OPPS Non-Chemotherapy Infusion Drug Administration Codes

Crosswalk From Discontinued Q-Codes to CPT Codes for Use in CY 2005

CPT Code	Description	SI	APC	Corresponding HCPCS code	Maximum number of units of the APC OCE will assign without modifier 59	Maximum number of units of the APC OCE will assign with modifier 59
90780	IV infusion therapy, 1 hour	T	120	Q0081	1	4
90781	IV infusion, additional hour	N	--	--	0	0

Beginning January 1, 2005, payment for drug administration services that were reported using Q0081, Q0083 and Q0084 will continue to be made on a per visit basis in CY 2005, despite the use of CPT codes for individual drug administration services provided. Available cost data used for setting payment rates for 2005 consist of 2003 data from HCPCS codes Q0081, Q0083 and Q0084, each of which reported per-day costs. For CY 2005 APC payment rates, refer to Addendum B on the CMS web site at www.cms.hhs.gov/providers/hopps.asp.

230.2.2 -- Administration of Chemotherapy Drugs by Infusion

(Rev.573, Issued: 06-03-05, Effective: 01-01-05, Implementation: 06-01-05)

Effective for services furnished on or after January 1, 2005, hospitals paid under the OPPS (12x and 13x bill types) should report an appropriate CPT code for chemotherapy drug administration by infusion. Hospitals are instructed to abide by the 2005 CPT definitions of these codes.

For services furnished in hospital outpatient departments prior to January 1, 2005, chemotherapy drug infusions were reported using HCPCS alphanumeric code Q0084, Administration of Chemotherapy by Infusion only, per visit.

Table 1 maps the CPT codes that are new for OPPS to the previously reported Q-codes, and provides APC payment group assignments. The OCE groups all CPT codes billed for chemotherapy drug infusions into a single unit of the corresponding APC, yielding a single per-encounter payment.

CPT codes 96412 and 96423 are add-on codes, and will be used by Hospitals to report an additional infusion hour, up to eight units per line billed. Infusions lasting longer than 9 hours will report additional infusion hours on a separate line of the corresponding add-on code as appropriate (limit of 8 units per line).

*OCE logic assumes that all services for chemotherapy infusions billed on the same date of service were provided during the same encounter. In those unusual cases where the beneficiary makes two separate visits to the hospital for chemotherapy infusions in the same day, the hospital reports modifier 59 for chemotherapy infusion codes during the second encounter that were also furnished in the first encounter. The OCE identifies modifier 59 and pays up to a maximum number of units per day, as listed in **Table 1**.*

EXAMPLE 1

A beneficiary receives one injection of anti-neoplastic drugs and an infusion for 2 hours of anti-neoplastic drugs in one encounter. The patient leaves the hospital and later that same day returns to the hospital for two injections of anti-neoplastic drugs and a 3 hour infusion of non anti-neoplastic drugs. To bill for the first encounter, the *hospital reports one unit of 96400 (without modifier 59), one unit of 96410, and one unit of 96412 (without modifier 59). To bill for the second encounter, the hospital reports one unit of 96400 (with modifier 59), one unit of 96400 (without modifier 59), one unit of 90780 (without modifier 59), and two units of 90781 (without modifier 59). The hospital will be paid two units of APC 116 (once for each encounter with 96400 - one unit in the first, two units in the second)), one unit of APC 117 (for the one unit of 96410 and the one unit of 96412), and one unit of APC 120 (for the one unit of 90780 and two units of 90781). (**NOTE:** See §230.1 for drug billing instructions.)*

EXAMPLE 2

*A beneficiary receives an infusion of anti-neoplastic drugs for 2 hours using a hydrating solution to which the anti-neoplastic drug has been added, without a specific medically necessary order for hydration. The hospital reports one unit of 96410 and one unit of 96412. The OCE will pay one unit of APC 117 (for the one unit each of 96410 and 96412). (**NOTE:** See §230.1 for drug billing instructions.)*

230.2.3 -- Administration of Chemotherapy Drugs by a Route Other Than Infusion

(Rev.573, Issued: 06-03-05, Effective: 01-01-05, Implementation: 06-01-05)

*OCE logic assumes that all services for chemotherapy drug administration by a route other than infusion that are billed on the same date of service were provided during the same encounter. In those unusual cases where the beneficiary makes two separate visits to the hospital for chemotherapy treatment in the same day, the hospital reports modifier 59 for chemotherapy drug administration (by a route other than infusion) codes during the second encounter that were also furnished in the first encounter. The OCE identifies modifier 59 and pays up to a maximum number of units per day, as listed in **Table 1**.*

230.2.4 -- Administration of Non-Chemotherapy Drugs by Infusion

(Rev.573, Issued: 06-03-05, Effective: 01-01-05, Implementation: 06-01-05)

Hospitals will report CPT code 90780 (IV infusion therapy, up to 1 hour) to indicate an infusion of drugs other than anti-neoplastic drugs furnished on or after January 1, 2005. CPT code 90781 (IV infusion, each additional hour (up to 8 hours)) will be used to report an additional infusion hour, up to eight units per line billed. Infusions lasting longer than 9 hours will report additional infusion hours on a separate line of 90781 as appropriate (limit of 8 units per line).

Medicare's general requirements regarding physician supervision of hospital outpatient services meet the physician supervision requirements for use of CPT codes 90780 and 90781. (Reference: Medicare Benefit Policy Manual, Pub.100-02, Chapter 6, §20.4.1.)

CPT codes 90780 and 90781 should not be reported when the infusion is a necessary and integral part of separately payable OPPS procedure.

CPT codes 90780 and 90781 report the duration of an infusion, regardless of the number of drugs infused; therefore, hospitals may bill one unit of CPT code 90780 for each encounter, but not for each drug infused.

The OCE will pay one APC for each encounter reported by CPT code 90780, and will only pay one APC for 90780 per day (unless Modifier 59 is used). Payment for additional hours of infusion reported by CPT code 90781 is packaged into the payment for the initial infusion. While no separate payment will be made for units of CPT code 90781, hospitals are instructed to report all codes that appropriately describe the services provided and the corresponding charges so that CMS may capture specific historical hospital cost data for future payment rate setting activities.

*OCE logic assumes that all services for non-chemotherapy infusions billed on the same date of service were provided during the same encounter. Where a beneficiary makes two separate visits to the hospital for non-chemotherapy infusions in the same day, the hospital reports modifier 59 for non-chemotherapy infusion codes during the second encounter that were also furnished in the first encounter. The OCE identifies modifier 59 and pays up to a maximum number of units per day, as listed in **Table 2**.*

EXAMPLE 1

*A beneficiary receives infused drugs that are not anti-neoplastic drugs (including hydrating solutions) for 2 hours. The hospital reports one unit of CPT code 90780 and one unit of CPT code 90781. The OCE will pay one unit of APC 120. Payment for the unit of 90781 is packaged into the payment for one unit of APC 120. (**NOTE**: See §230.1 for drug billing instructions.)*

EXAMPLE 2

*A beneficiary receives infused drugs that are not anti-neoplastic drugs (including hydrating solutions) for 12 hours. The hospital reports one unit of CPT code 90780, eight units of CPT code 90781, and on a separate line, three units of CPT code 90781. The OCE will pay one unit of APC 120. Payment for the 11 units (total) of 90781 is packaged into the payment for one unit of APC 120. (**NOTE:** See §230.1 for drug billing instructions.)*

EXAMPLE 3

*A beneficiary experiences multiple attempts to initiate an intravenous infusion before a successful infusion is started 20 minutes after the first attempt. Once started, the infusion lasts one hour. The hospital reports one unit of 90780 to identify the 1 hour of infusion time. The 20 minutes spent prior to the infusion attempting to establish an IV line are not separately billable in OPPS. The OCE pays one unit of APC 120. (**NOTE:** See §230.1 for drug billing instructions.)*

230.2.5 -- Administration of Non Chemotherapy Drugs by a Route Other Than Infusion

(Rev.573, Issued: 06-03-05, Effective: 01-01-05, Implementation: 06-01-05)

*Hospitals will report the appropriate CPT codes (including, but not limited to, those listed in **Table 3**) to describe the administration of non-chemotherapy drugs by a route other than infusion.*

*The drug administration services listed in **Table 3** have been reported using CPT codes and paid under the OPPS since the implementation of the OPPS. These services continue to be reported using CPT codes and payment continues to be based on the corresponding APC group.*

Table 3: OPPS Non-Chemotherapy, Non-Infusion Drug Administration
Drug Administration CPT Codes That Continue to be Reported in CY 2005

HCPCS	SI	APC	Description
90782	X	353	Injection SC/IM
90783	X	359	Injection IA
90784	X	359	Injection IV
90788	X	359	Injection of antibiotic
90799	X	352	Ther/prophylactic/dx inject

230.2.6 – Use of Modifier 59

(Rev.573, Issued: 06-03-05, Effective: 01-01-05, Implementation: 06-01-05)

With respect to chemotherapy administration and non-chemotherapy drug infusion, the use of Modifier 59 indicates a distinct encounter on the same date of service. In the case of chemotherapy administration or non-chemotherapy infusion, Modifier 59 is appended to drug administration HCPCS codes that meet the following criteria:

1. *The drug administration occurs during a distinct encounter on the same date of service of previous drug administration services; and*
2. *The same HCPCS code has already been billed for services provided during a separate and distinct encounter earlier on that same day.*

CPT modifier 59 is NOT to be used when a beneficiary receives infusion therapy at more than one site or when an infusion is stopped and then started again in the same encounter.

The OCE will pay one unit of the corresponding APC for each separate encounter, up to the daily maximum listed in tables 1 and 2. Units of service exceeding daily maximum allowances will be packaged and no additional payment will be made.

EXAMPLE 1

*A beneficiary receives infused non anti-neoplastic drugs for 2 hours. The hospital reports one unit of CPT code 90780 and one unit of CPT code 90781 for the services in the encounter. The beneficiary leaves the hospital and returns for a second encounter in which the beneficiary again receives infused non anti-neoplastic drugs for 2 hours. For the second encounter on the same date of service, the hospital reports one unit of CPT code 90780 with modifier 59 and one unit of CPT code 90781 with modifier 59. The OCE will pay 2 units of APC 120 (i.e., one unit for each encounter). (**NOTE:** See §230.1 for drug billing instructions.)*

EXAMPLE 2

*A beneficiary receives one injection of anti-neoplastic drugs and 2 hours of an infusion of anti-neoplastic drugs in the first encounter. The hospital reports one unit of 96400 and one unit each of 96410 and 96412. The OCE will pay one unit of APC 116 (for one unit of 96400) and one unit of APC 117 (for the one unit each of 96410 and 96412). Later on the same date of service, the beneficiary returns to the hospital and receives two injections of anti-neoplastic drugs. For the second encounter, the hospital reports one unit of 96400 with modifier 59, and one unit of 96400 without modifier 59. The hospital will be paid one unit of APC 116 for two units of 96400 (as the second unit of 96400 provided during the second encounter is bundled with the first unit of 96400 provided during the second encounter). (**NOTE:** See §230.1 for drug billing instructions.)*

EXAMPLE 3

*A beneficiary receives three injections of anti-neoplastic drugs and 2 hours of infusion of anti-neoplastic drugs in one encounter. The beneficiary returns to the hospital in a separate encounter on the same date for administration of hydrating solution provided via infusion over 2 hours to treat dehydration and vomiting. For services in the first encounter, the hospital reports CPT codes as three units of 96400, one unit of 96410, and one unit of 96412 (all without modifier 59). For services in the second encounter, the hospital reports one unit of CPT code 90780 and one unit of CPT code 90781. The OCE pays one unit of APC 116 (for the 3 units of 96400), one unit of APC 117 (for the one unit of 96410 and 96412) and one unit of APC 120 (for the one unit of 90780 and the one unit of 90781). No modifiers are needed when billing for services in the second encounter as these services were not provided during the first encounter on that day. (**NOTE:** See §230.1 for drug billing instructions.)*

EXAMPLE 4

*A beneficiary receives three injections of anti-neoplastic drugs and 2 hours of infusion of anti-neoplastic drugs in one encounter. The beneficiary has a second encounter on the same date of service in which the beneficiary receives three injections of anti-neoplastic drugs and one hour of infusion of drugs other than anti-neoplastic drugs (includes hydrating solution). For the first encounter the hospital reports CPT codes as follows: Three units of 96400, one unit of 96410, and one unit of 96412 (without modifier 59). For the second encounter, the hospital bills three units of CPT code 96400 (one unit with modifier 59, two units without modifier 59), and one unit of CPT code 90780 (without modifier 59). The OCE pays two units of APC 116 (one for each encounter - 3 units of 96400 during the first encounter and 3 units during the second), one unit of APC 117 (for the one unit each of 96410 and 96412 during the first encounter) and one unit of APC 120 (for the one unit of 90780 during the second encounter). (**NOTE:** See §230.1 for drug billing instructions.)*

230.2.7 Billing for Infusion Hours

(Rev.573, Issued: 06-03-05, Effective: 01-01-05, Implementation: 06-01-05)

***Initial Hour of Infusion** - Hospitals are to report first hour infusion codes (e.g., 90780, 96410, 96422) after 15 minutes of infusion. Infusions lasting 15 minutes or less should be billed as intravenous (or intra-arterial) pushes and must be coded accordingly.*

***Intravenous or Intra-Arterial Push** - Hospitals are to bill push codes (e.g. 96408, 96420, 90783, 90784) for services that meet existing CPT guidelines and meet either of the following criteria:*

- *A healthcare professional administering an injection is continuously present to administer and observe the patient; and*

- *An infusion is administered lasting 15 minutes or less.*

Subsequent Infusion Hours *- Hospitals are to report additional hours of infusion (e.g., 90781, 96412, 96423) (beyond the first hour) in accordance with §230.2.2 and §230.2.4, and only after more than 30 minutes have passed from the end of the previously billed hour. Therefore, to bill a subsequent hour of infusion, more than 90 minutes of infusion services must be provided.*

EXAMPLE 1

*A non-chemotherapy infusion lasts 3 hours and 7 minutes. The hospital will bill one unit of 90780 (for the first hour) and two units of 90781 (for the second and third hour). Hospitals can not bill push codes for carryover infusion services not otherwise eligible for billing of a subsequent infusion hour. Payment will be one unit of APC 120. (**NOTE:** See §230.1 for drug billing instructions.)*