Chemotherapy: An Overview

Page updated: November 2023

This section contains overview information for policy related to billing for chemotherapy services, including infusion policy and authorization requirements for chemotherapy services. Billing policy details about chemotherapy drugs can be found in the following Part 2 manual sections:

- *Chemotherapy: Drugs A-D Policy*
- *Chemotherapy: Drugs E-O Policy*
- *Chemotherapy: Drugs P-Z Policy*

Important Notice and TAR Requirement

All listed chemotherapy drugs may be approved for FDA-labelled indications, dosages and usages. An approved *Treatment Authorization Request* (TAR) is required for off-label use to justify medical necessity. It must meet current standards of practice, current medical literature or treatment guidelines, in accordance with statutory requirements (22 CCR § 51313(4)). Billing codes and utilization management criteria are listed with each code. Experimental Services are not a benefit. Investigational Services are covered in accordance with statutory requirements (22 CCR § 51303(g)). Authorization is required for dosages exceeding the maximum recommended dosages as approved by the FDA.

Providers submitting electronic TARs (eTARs) must select the Special Handling description "Cannot Bill Direct, TAR is Required," which is found in the *Patient Information* section of the eTAR application.

Reimbursement Methodology

‹‹Physician-administered drugs are reimbursed at the Medicare rate of reimbursement when established and published by the Centers for Medicare & Medicaid Services (CMS). The Medicare rate is currently defined as average sales price (ASP) plus 6 percent. The pharmacy rate is currently defined as the lower of (1) the National Average Drug Acquisition Cost (NADAC), or when the NADAC is not available, the wholesaler acquisition cost (WAC) plus 0 percent; (2) the federal upper limit (FUL); or (3) the maximum allowable ingredient cost (MAIC).››

Reimbursement is determined by the cost of the injection, plus the physician's injection administration fee for the first billed unit of drug. The price listed on the Medi-Cal Rates page of the Medi-Cal website for each physician-administered drug includes the one-time injection administration fee of $4.46. Since the injection administration fee is applied only once for each drug administered, subsequent units claimed will have the administration fee subtracted from the published rate.

Intravenous Infusion

CPT® codes 96413 (chemotherapy administration, intravenous infusion technique; up to one hour, single or initial substance/drug) and 96415 (...each additional hour, one to eight hours) are reimbursable only when performed by a physician or by a qualified assistant under physician's direct supervision. The National Provider Identifier (NPI) must be entered in the *Attending* field (Box 76)/*Billing Provider Info and Phone Number* field (Box 33A) of the claim form in order for the claim to be reimbursed. Claims for code 96415 require medical justification if billed for more than one hour.

Place of Service Codes/Facility Type Codes

In addition, providers may only bill these codes with the following Place of Service or facility type codes:

CMS-1500 Use Code	UB-04 Use Code	Facility Type/Place of Service
11	79	Clinic
53, 71, 72	71, 73, 74, 75, 76	Clinic
24	83	Special Facility
22, 65	13, 72	Hospital/Clinic
23	14	Hospital
42	‹‹None››	Ambulance (air or Water)

These codes are not reimbursable when rendered to hospital inpatients, patients in a Nursing Facility Level A (NF-A), NF Level B (NF-B) or at home because a nurse usually performs intravenous infusion in these facilities.

Additional Hours: CPT Code 96415

CPT code 96415 is generally reimbursable for a maximum of one additional hour of administration. When code 96415 is billed in conjunction with cisplatin (HCPCS code J9060), a maximum of five additional hours may be reimbursed.

Additional Hours Multiple Sequential Infusions

Reimbursement for code 96415 is limited to a maximum of three hours when billed in conjunction with multiple-sequential chemotherapy drugs administered by infusion technique. The first hour of infusion services is billed with code 96413 (chemotherapy administration, intravenous infusion technique; up to one hour, single or initial substance/drug).

Claims submitted with code 96415 must include documentation that states the names of the drugs administered, the individual infusion time for each and a statement that "multiple chemotherapeutic agents were administered sequentially." This information should appear in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) of the claim or on an attachment.

Prolonged Intravenous Infusion (More than Eight Hours): "By Report" Billing Required

"By Report" billing is required for CPT code 96416 (chemotherapy administration, intravenous infusion technique, initiation of prolonged chemotherapy infusion [more than eight hours], requiring the use of a portable or implantable pump). A report with enough information to manually price the procedure must be attached to the claim or written in the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) of the claim. The report must detail the physician's services including, but not limited to, the number of hours spent attending to the patient.

Cancer Clinical Trials Guidelines

Pursuant to *Section 1396d(gg)(2)* of *Title 42 of the United States Code*, Medi-Cal covers routine patient care costs for beneficiaries participating in a qualifying clinical trial.

Please refer to the *Clinical Trials Policy* section of the provider manual for details.

Legend

Symbols used in the document above are explained in the following table.

Symbol	Description
‹‹	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
››	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.