



Chemotherapy Related Services - Impact on Error Rates

Errors assessed by the Comprehensive Error Rate Testing (CERT) contractor for chemotherapy-related services have a large impact on error rates for WPS Medicare and on a national level. According to Medicare guidelines, medical record documentation must support all services billed, the medical necessity of the services, and be legible in order for the CERT contractor to complete a fair review.

WPS Medicare has noted a recent increase in errors assessed for chemotherapy-related services. The following is an example of review findings received from the CERT Contractor:

Billed Service: Therapeutic, prophylactic, or diagnostic injection and injection, pegfilgrastim (Neulasta), 6mg
Date of Service (DOS): 04/15/2011

CERT Reviewer Comment:

Missing are valid orders from the ordering provider to support billed services. Received signed and dated progress note dated 02/23/2011 for order for Neulasta for this date only, Treatment Plan for 10/13/2010 with Chemo orders and order for Neulasta for 02/23/2011, office visit note dated 04/13/2011 with no mention of ordering Neulasta for billed DOS 04/15/2011, administration record signed by the RN and illegible co-signature of the MD/supervising MD, and laboratory results.

Requested valid orders twice from the billing provider and received no response from follow-up request and received duplicate documentation and a typed letter addressed to CERT stating the following "Based on the patient's lab values the patient received an injection of Neulasta. The patient did not see the physician that day, but the physician signed off on the flow sheet that documents the Neulasta injection."

How can the aforementioned errors be avoided?

For medical review purposes, Medicare requires that services provided/ordered be authenticated by the author. The method used must be a hand written or an electronic signature. Stamp signatures are not acceptable. To learn more about signature requirements, including exceptions, please refer to:
<https://www.cms.gov/MLN MattersArticles/downloads/MM6698.pdf>

In addition to documenting the medical necessity of the chemotherapy services, records should include a signed physician order for drug(s) administered, dosage, frequency and duration of treatment. The physician must clearly document in the medical record (e.g., progress note) his or her intent that the chemotherapy be performed. If a protocol is used, a copy of the protocol should be submitted. Providers should send all aforementioned information when sending medical records to the CERT contractor.

In an effort to decrease the paid claims error rate and to assist providers in avoiding common errors when billing for chemotherapy administration, please keep in mind the

following reminders and tips for submitting documentation for chemotherapy related services. Please be aware that this list is **not all-inclusive**.

Chemotherapy Administration documentation should include:

- Clear indication of patient name, date of birth, and date of service(s)
- Name and dosage of drug administered
- Signed physician order for drug(s) administered, dosage, frequency and duration of treatment
- Documentation of medical necessity of the treatment

Tips to consider when performing chemotherapy administration:

- If performed to facilitate the chemotherapy infusion or injection, the following services are included in the chemotherapy administration and are **not separately billable**:
 - Use of local anesthesia;
 - IV access;
 - Access to indwelling IV, subcutaneous catheter or port;
 - Flush at conclusion of infusion;
 - Standard tubing, syringes and supplies; and
 - Preparation of chemotherapy agent(s).
- If a **significant separately identifiable** evaluation and management (E/M) service is performed, the appropriate E/M code should be reported utilizing modifier 25 in addition to the chemotherapy code. For an evaluation and management service provided on the same day, a different diagnosis is not required.