Oncology Reimbursement Coding Update 2017

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There is a saying that "a change is as good as a rest," which may indeed be true. However, the 2017 final regulations, code updates, and other reimbursement changes once again bring challenges to oncology coding and billing. To help you update your respective chargemasters, fee schedules, and other reimbursement documents to ensure compliance with coding and billing guidelines, we've compiled all of the oncology-specific information you need to know going into 2017.

New & Revised Procedure Codes

Each year there are new codes, revised codes, and updates to coding guidelines. For calendar year (CY) 2017, a new procedure code has been created for the application of an on-body injector:

- **96377**: Application of on-body injector (includes cannula insertion) for timed subcutaneous injection.

According to code definition, code **96377** differs from code **96372** (therapeutic subcutaneous or intramuscular injection) because it describes the work of preparing and applying the on-body injector, rather than the manual injection of a drug.

The 2016 codes for moderate sedation were deleted, and replaced with these redefined codes:

- **99151**: Moderate sedation services provided by the same physician or other qualified healthcare professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; initial 15 minutes of intraservice time, patient younger than 5 years of age.
- **99152**: Patient age 5 years or older.
- **+99153**: Each additional 15 minutes intraservice time. (List separately in addition to code for primary service.)
- **99155**: Moderate sedation services provided by a physician or other qualified healthcare professional other than the physician or other qualified healthcare professional performing the diagnostic or therapeutic service that the sedation supports; initial 15 minutes of intraservice time, patient younger than 5 years of age.
- **99156**: Patient age 5 years or older.
- **+99157**: Each additional 15 minutes intraservice time. (List separately in addition to code for primary service.)

In addition, moderate sedation has been included by definition in a number of surgical and procedure codes in the *CPT*© *Manual*. This means that sedation will not be coded and charged separately for an increasing number of services.

In addition to the CPT procedure codes for moderate sedation, there is a new HCPCS code for gastrointestinal endoscopic services:

- **G0500**: Moderate sedation services provided by the same physician or other qualified healthcare professional performing a gastrointestinal endoscopic service (excluding biliary procedures) that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; initial 15 minutes of intraservice time, patient age 5 years or older.

HCPCS Level II Code Updates

In addition to changes in procedure codes, there are new and updated HCPCS modifiers, some of which are discussed in more detail in other sections of this article. **Modifier L1** (Provider attestation that the hospital laboratory test is not packaged under the Hospital OPPS) is the only HCPCS modifier deleted for CY 2017.

As a result of changes to payments for off-campus provider-based departments, below are one new and one updated modifier for billing under the Outpatient Prospective Payment System (OPPS):

- **Modifier PN**: Non-excepted service provided at an off-campus, outpatient, provider-based department of a hospital.
- **Modifier PO**: Excepted service provided at an off-campus, outpatient, provider-based department of a hospital.

Additional new HCPCS Level II modifiers include:

- **Modifier FX**: X-ray taken using film
- **Modifier Q2**: Demonstration procedure/service (Note: this is an existing modifier with revised definition)
- **Modifier V1**: Demonstration modifier 1
- **Modifier V2**: Demonstration modifier 2
- **Modifier V3**: Demonstration modifier 3
- **Modifier ZB**: Pfizer/Hospira.

Modifier JW

Although not part of the year-end coding changes, CMS issued an update to the requirement for reporting **modifier JW** (drug amount discarded/not administered to any patient). Effective Jan. 1, 2017, all providers (hospitals, freestanding centers, and physician offices) will be required to use **modifier JW**, and they will continue to be required to document the amount of discarded drug in the individual patient's medical record. This policy change was announced in Transmittal 3538 (Change Request 9603), learn more at: cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9603.pdf.

Medicare's discarded drug policy is located in Chapter 17 of the Medicare Claims Processing Manual. Briefly, it states that when a provider administers part of a single-use vial or other single-use package to a Medicare patient, and the rest of the container must be discarded, Medicare will pay both for the amount that was administered and the amount that was discarded. Note that this policy applies only to single-use containers or single-use vials. If part of a multi-use container is discarded, the provider may bill only for the amount that was actually administered to the patient.

The provider must report the drug on the claim as two separate charges: one claim line for the amount administered (with no modifier), and one claim line for the discarded drug amount, with **modifier JW**. For example, code **J9035** represents Avastin (bevacizumab), 1 unit per 10 mg. If a patient is given 980 mg from single use vials that total 1,000 mg, and the remainder of the last vial is discarded (20 mg), the provider should report the following:

- **J9035** x 98 units (administered 980 mg)
- **J9035-JW** x 2 units (wasted 20 mg).

Remember to price each line appropriately as well; the charge for the drug administered and the charge for the drug amount wasted should equal the total dollar amount of drug billed. Providers will be paid for both claim lines; CMS simply wants to track the amount Medicare pays for wasted drugs.

CMS states that **modifier JW** should not be used "if the billing unit is equal to or greater than the total actual dose and the amount discarded." For example, 2 mcg of sincalide is administered to a patient from a 5 mcg single use vial, and the remainder is discarded. Sincalide is reported with code **J2805** (Injection, sincalide, 5 micrograms). Since 1 unit of the code is equal to the total amount administered plus the amount discarded, the provider will report 1 unit of code **J2805** and **modifier JW** will not be applied.

Modifier JW is reported with drugs and biologicals (preparations made from living organisms, such as vaccines, antigens, antitoxins, etc.), with the exception of drugs provided under the Competitive Acquisition Program (CAP). Unless your contractor instructs otherwise, this modifier should not be applied to codes for radiopharmaceuticals, which are in a separate category.

Drugs Administered in Portable Pumps

MLN Matters published a special edition April 26, 2016, to clarify charging for prolonged drug and biological infusions started incident-to a physician's service using an external pump. Learn more at: cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1609.pdf.

In some situations, a hospital outpatient department or physician office may:

- Purchase a drug for a medically reasonable and necessary prolonged drug infusion;
- Begin the drug infusion in the outpatient department or physician office using a portable pump;
- Send the patient home for a portion of the infusion; and
- Have the patient return at the end of the infusion period.

According to these clarified instructions, the drug or biological is billable to the Medicare Administrative Contractor (MAC), even though the entire administration of the drug or biological did not occur in the physician's office or the hospital outpatient department. According to CMS, the drug or biological continues to meet the requirements for the incident-to benefit as the physician or hospital incurred a cost for the drug or biological and the administration of the drug began in the physician's office or hospital outpatient department incident-to a physician's services.

Medicare's payment for the administration of the drug or biological billed to the MAC also includes payment for all equipment used in furnishing the service. This means that equipment, such as the portable

Table 1. Current Biosimilar Codes and Modifiers

HCPCS CODE	DESCRIPTOR	SI	APC	EFFECTIVE DATE	MODIFIER
Q5101	Injection, filgrastim (G-CSF), biosimilar, 1 mcg	G	1822	03/06/2015	ZA – Novartis/Sandoz
Q5102	Injection, infliximab, biosimilar, 10 mg	K	1761	04/05/2016	ZB – Pfizer/Hospira

infusion pump used to begin administration of the drug or biological that the patient takes home to complete the infusion is not separately billable as durable medical equipment for a drug or biological paid under the incident-to benefit. This information was updated in *MLN Matters* (cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9749.pdf) to provide the following HCPCS code that will be used to report the administration charge:

- **G0498**: Chemotherapy administration, intravenous infusion technique; initiation of infusion in the office/other outpatient setting using office/other outpatient setting pump/supplies, with continuation of the infusion in the community setting (e.g., home, domiciliary, rest home or assisted living) using a portable pump provided by the office/other outpatient setting, includes follow-up office/other outpatient visit at the conclusion of the infusion.

The full amount drug or biological administered via pump will also be billed to the MAC. HCPCS Level II code **G0498** is reported by the physician office or outpatient hospital department that fills and initiates the portable pump. Last, Medicare states that this code is effective Jan. 1, 2016, so it may be necessary to retroactively file corrected claims.

Biosimilar Products

A biosimilar product has no clinically meaningful differences from a previously-approved reference product, only minor differences in clinically inactive components. CMS updates coding and billing information under the OPPS on a quarterly basis. The information effective July 1, 2016, included a reminder that OPPS claims for separately paid biosimilar biological products are required to include a modifier that identifies the manufacturer of the product. Current biosimilars codes and modifiers are shown in Table 1, above.

Biodegradable Material

This same quarterly updated document states that effective June 30, 2016, the following HCPCS Level II code was deleted:

- **C9743**: Injection/implantation of bulking or spacer material (any type) with or without imaging guidance (not to be used if a more specific code applies).

Code **C9743** was replaced with a Category III CPT code, effective July 1, 2016:

- **0438T**: Transperineal placement of biodegradable material, peri-prostatic (via needle), single or multiple, includes image guidance.

This new code will be reported by the hospital for the technical service and by the physician for the professional service. Remember that Category III temporary procedure codes may not be reimbursed by all insurers, so check local payer policies for coverage.

Spacer material separates the anterior rectal wall from the prostate by injecting an absorbable hydrogel- or saline-filled balloon that naturally biodegrades within six months after implantation. The goal of utilizing spacer material is to reduce the radiation dose to the rectum. These materials generally maintain shape and position during treatment, and then degrade or break down within 6 months after implantation, after treatment has completed.

The full text of *MLN Matters MM9658* is located at: cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9658.pdf.

Smoking Cessation

According to CMS, effective Sept. 30, 2016, HCPCS codes **G0436** (Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes) and **G0437** (Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes) are deleted. The services previously represented by HCPCS codes **G0436** and **G0437** should be billed under existing CPT codes **99406** (Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes) and **99407** (Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes)

Table 2. Select Deleted Drug Codes & Their CY 2017 Code Replacements

2017 CODE		DELETED 2016 CODE	
J9325	Injection, talimogene laherparepvec, per 1 million plaque forming units	**C9472**	Injection, talimogene laherparepvec, 1 million plaque forming units (PFU)
J9205	Injection, irinotecan liposome, 1 mg	**C9474**	Injection, irinotecan liposome, 1 mg
J9295	Injection, necitumumab, 1 mg	**C9475**	Injection, necitumumab, 1 mg
J9145	Injection, daratumumab, 10 mg	**C9476**	Injection, daratumumab, 10 mg
J9176	Injection, elotuzumab, 1 mg	**C9477**	Injection, elotuzumab, 1 mg
J9352	Injection, trabectedin, 0.1 mg	**C9480**	Injection, trabectedin, 0.1 mg
J8670	Rolapitant, oral, 1 mg	**Q9981**	Rolapitant, oral, 1 mg
J0883	Injection, argatroban, 1 mg (for non-ESRD use)	**C9121**	Injection argatroban, per 5 mg
J0884	Injection, argatroban, 1 mg (for ESRD on dialysis)		
J1942	Injection, aripiprazole lauroxil, I mg	**C9470**	Injection, aripiprazole lauroxil, 1 mg
J7320	Hyaluronan or derivative, Genvisc 850, for intra-articular injection 1 mg	**Q9980**	Hyaluronan or derivative, Genvisc 850, for intra-articular injection 1 mg
J7322	Hyaluronan or derivative, Hymovis, for intra-articular injection 1 mg	**C9471**	Hyaluronan or derivative, Hymovis, for intra-articular injection 1 mg
J2182	Injection, mepolizumab, 1 mg	**C9473**	Injection, mepolizumab, 1 mg
J2840	Injection, sebelipase alfa, 1 mg	**C9478**	Injection, sebelipase alfa, 1 mg
J7342	Instillation, ciprofloxacin otic suspension, 6 mg	**C9479**	Instillation, ciprofloxacin otic suspension, 6 mg
J2786	Injection, reslizumab, 1 mg	**C9481**	Injection, reslizumab, 1 mg

respectively. The full text of *MLN Matters* MM9768 is located at: cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9768.pdf.

Advanced Illness

The second quarter 2016 issue of *Coding Clinic for HCPCS*, included the following new codes:

- **S0311**: Comprehensive management and care coordination for advanced illness, per calendar month
- **S3854**: Gene expression profiling panel for use in the management of breast cancer treatment.

HCPCS codes that begin with the letter "S" are not accepted by Medicare, but may be reimbursed by other insurers, such as Blue Cross Blue Shield.

Telehealth

Effective Jan. 1, 2017, there are two new HCPCS codes for critical care telehealth:

- **G0508**: Telehealth consultation, critical care, initial, physicians typically spend 60 minutes communicating with the patient and providers via telehealth
- **G0509**: Telehealth consultation, critical care, subsequent, physicians typically spend 50 minutes communicating with the patient and providers via telehealth.

Mobility Assistance & Care Planning

There is an add-on HCPCS code that will be reported in addition to a patient office visit for patients that use special mobility equipment and an add-on code for comprehensive care planning:

- **G0501**: Resource-intensive services for patients for whom the use of specialized mobility-assistive technology (such as adjustable height chairs or tables, patient

Table 3. Replacement HCPCS Codes & Definitions for Select Drugs for CY 2017

2017 CODE	2017 DEFINITION	2016 CODE	2016 DEFINITION
J7201	Injection, factor IX, fc fusion protein, (recombinant), Alprolix, 1 IU	**J7201**	Injection, factor IX, fc fusion protein, (recombinant), 1 IU
J0573	Buprenorphine/naloxone, oral greater than 3 mg, but less than or equal to 6 mg	**J0573**	Buprenorphine/naloxone, oral greater than 3 mg, but less than or equal to 3.1 to 6 mg
J0570	Buprenorphine implant, 74.2 mg	**N/A**	
J1745	Injection, infliximab, excludes biosimilar, 10 mg	**J1745**	Injection, infliximab, 10 mg
J3357	Ustekinumab, for subcutaneous injection, 1 mg	**J3357**	Injection, ustekinumab, 1 mg
J7340	Carbidopa 5 mg/levodopa 20 mg enteral suspension, 100 ml	**J7340**	Carbidopa 5 mg/ levodopa 20 mg enteral suspension
P9072	Platelets, pheresis, pathogen reduced or rapid bacterial tested, each unit	**P9072**	Platelets, pheresis, pathogen reduced, each unit

lift, and adjustable padded leg supports) is medically necessary and used during the provision of an office/outpatient, evaluation and management visit (list separately in addition to primary service).

- **G0506**: Comprehensive assessment of and care planning by the physician or other qualified healthcare professional for patients requiring chronic care management services, including assessment during the provision of a face-to-face service (billed separately from monthly care management services). (Add-on code, list separately in addition to primary service.)

Drug Codes

Effective Jan. 1, 2017, there are new codes, revised codes, and replaced codes for drugs, biologicals, and substances. Following are new drug HCPCS codes not impacted by code definition changes:

- **C9482**: Injection, sotalol hydrochloride, 1 mg
- **C9483**: Injection, atezolizumab, 10 mg
- **J1130**: Injection, diclofenac sodium, 0.5 mg.

Bendamustine is a chemotherapy drug used for lymphoma and leukemia. For CY 2017, there is a new code for Bendeka™ (**J9034**, Injection Bendamustine HCl [Bendeka], 1 mg) and the existing code has been revised to apply only to Treanda™ (**J9033**, Injection, bendamustine HCl [Treanda], 1 mg).

New drug HCPCS codes for clotting factors effective Jan. 1, 2017, include:

- **C9140**: Injection, factor VIII (antihemophilic factor, recombinant), (Afstyla), 1 IU
- **J7179**: Injection, von Willebrand factor (recombinant), (Vonvendi), 1 IU vwf:rco
- **J7202**: Injection, factor IX, albumin fusion protein, (recombinant), Idelvion, 1 IU
- **J7207**: Injection, factor VIII, (antihemolytic factor, recombinant), pegylated, 1 IU
- **J7209**: Injection, factor VIII, (antihemolytic factor, recombinant), (Nuwiq), 1 IU
- **J7175**: Injection, factor X, (human) 1 IU.

HCPCS codes that will be deleted on Jan. 2017, include:

- **C9139**: Injection factor IX, albumin fusion protein (recombinant), Idelvion, 1 IU
- **C9137**: Injection, factor VIII, (antihemolytic factor, recombinant), pegylated, 1 IU
- **C9138**: Injection, factor VIII, (antihemolytic factor, recombinant), (Nuwiq), 1 IU.

Table 2, page 19, shows select deleted codes and their replace codes for CY 2017. Table 3, above, lists replacement HCPCS codes and definitions for select drugs for CY 2017.

Effective Jan.1, 2017, the following HCPCS codes have been deleted and not replaced:

- **J0760:** Injection, colchicine, per 1 mg
- **J1590**: Injection, gatifloxacin, 10 mg.

Update: National Correct Coding Initiative Policy Manual

The 2017 edition of the NCCI Policy Manual includes the following instruction:

- CPT codes **77280–77290** (simulation-aided field settings) should not be reported for verification of the treatment field during a course of intensity modulated radiotherapy (IMRT) treatment.

This policy will be effective Jan. 1, 2017, and will impact physicians, freestanding radiation treatment centers, and hospital outpatient departments. OI