

compliance

Discontinued Services in Oncology

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Everyone working in oncology understands that there are days where not everything goes as planned. This could be due to an equipment malfunction, patients who may not be able to finish or who cannot be administered therapy during their scheduled visit, or patients who have a reaction to therapy. Regardless of the reason, the ability to bill for services will depend on why the service had to be discontinued. The key to identifying whether or how to bill for services hinges on the encounter (visit) documentation and how the discontinued service(s) was addressed.

Radiation Oncology Scenarios

In this specialty, service is considered discontinued when at least a partial dose of radiation was delivered. In situations where patients show up for their scheduled radiation treatment delivery but no radiation is delivered, there is no billable service. Treatment delivery codes identify that radiation was administered to the patient as part of their treatment plan. For example, if patients make it as far as the treatment room and are on the treatment table but it is determined that they cannot be treated and no therapeutic radiation is administered, there is no billable charge. Cancer programs and practices would *not* report a treatment delivery code, such as Current Procedural Terminology (CPT®) **77412** and **modifier 52** (reduced services for surgical procedures without anesthesia).

If patients are brought into the treatment room, positioned for treatment, and some of the therapeutic dose is delivered but patients signal that they cannot continue, billing for this type of discontinued service will depend on how the remaining dose was handled:

- **Scenario 1: The remaining therapeutic dose is administered separately on the next day.** In this scenario, the therapeutic planned dose of radiation is completed

the next day. Documentation would reflect that the patient's treatment was stopped before the full dose was delivered and the remaining dose is enough that it will be given separately the next day. The first portion is documented but is *not* billed. The treatment delivery is billed when the final portion of the planned dose is delivered. The dose is carried out in full, so there is no reduced service to be reported with split codes and modifiers.

- **Scenario 2: The remaining therapeutic dose is recalculated into the remaining fractions of treatment to increase the daily dose, but the patient still achieves the planned total dose.** In this scenario, physicians document that the remaining amount of radiation can be safely recalculated and added to the remaining fractions of treatment. The medical dosimetrist performs new basic dosimetry calculations for the remaining treatments and added dosage. With the appropriate orders and documentation, CPT **77300** is billed for the new calculations. The first portion of treatment is considered a completed delivered dose and is billed as normal with the corresponding treatment delivery code. The remaining fractions are also billed with the appropriate corresponding treatment delivery codes.
- **Scenario 3. The remaining therapeutic dose is determined by the physician to be so low that the treatment is considered complete and no adjustment is needed for the remaining course of treatment.** In this scenario, physicians document that the radiation amount remaining is minimal and that it will not have an impact on the radiobiological effects. Physicians document that the treatment is considered complete and no adjustment to the remaining fractions is needed. The treatment is billed and supported with the appropriate treatment delivery code.

Discontinuation of services does not only occur during treatment delivery. There may be scenarios that occur with patients prior to the treatment delivery process. For example, patients may agree to treatment and have the initial setup simulation performed but change their mind afterward or there is an error noted on the treatment plan and it must be replanned before treatment can commence. These billing scenarios are considered on a case-by-case basis.

If patients originally agree to treatment and then change their mind, the services provided to them up to the point of withdrawing from treatment can be billed. These services can be billed if the treatment planning was completed and patients alert the physician that they no longer want to proceed when they arrive for treatment or if patients simply call to express this change. An internal review is necessary to determine what services are considered billable by ensuring that only those services documented *prior* to the withdrawal from treatment are billed.

If, however, it is determined that there is an error or a change is needed in the treatment planning prior to treatment delivery—not due to a change by the patient but instead due to a change(s) made by staff or physicians—only one set of services is billable. In other words, it is not appropriate to penalize the patient with multiple charges for services that did not pass quality assurance or when a last-minute change is noted. In these scenarios, the services used to treat the patient are recommended to be the billed charges. This practice may result in need for credit of original charges or a notation that the original charge date was used but there was a change supported in the medical record. As with the other scenarios, these situations should be considered case-by-case, and an internal review is recommended to determine what happened to cause the needed change.

Medical Oncology Scenarios


On the medical oncology side, billing determination depends on what happened as part of the encounter and whether any drugs were administered to the patient or the planned procedure was fully completed.

- **Scenario 1: No drugs are administered to the patient.** In this scenario, if patients present and it is determined that they cannot be treated with the prescribed regimen (possibly due to a contraindication not previously identified or patients' lab values are not within acceptable levels to support treatment) and if no drugs are administered, there is no billable charge for the drugs or administration services. It may be possible to bill for the port flush or lab draw, depending on the situation, but the drugs are *not* billable.
- **Scenario 2: A portion of the prescribed therapy is administered before being discontinued.** In this scenario, if any portion of the drug is administered and discontinued due to some contraindica-

tion or reaction by patients, the administered and discarded drug(s) could be billed to the payer with the corresponding ICD-10-CM code to identify what occurred. Because many drug administration codes are time-based procedures, review the start/stop times to determine the most appropriate code based on the time of the administration. If the drug administration is discontinued at the onset of the planned infusion, the use of **modifier 52** (reduced service) or **modifier 53** (discontinued procedure) may be applicable because the minimum amount of time for the planned service was not met. If rescue medications are required for the patient's reaction, those medications and administration services may be billed with supporting documentation.

- **Scenario 3. Not able to complete procedure as planned.** In this example, patients are scheduled for a bone marrow biopsy to be performed; however, upon initiation of the procedure, the procedure

was not able to be carried out due to the patient's body habitus. Because the physician initiated the procedure but was not able to complete the procedure as planned, the service is considered billable; however, a modifier is necessary to indicate that the procedure was discontinued. In this scenario, hospitals would append **modifier 52** (reduced service) and physicians would append **modifier 53** (discontinued procedure).

Due to the various scenarios that may lead to questions about whether discontinued services can be billed, it is important for physicians to appropriately document what occurred. This assists staff in understanding how or what services can be billed and documents the patient's story for future encounters. 

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