Coding Tips, Hints & Pointers for Oncology Billing

Teri Bedard, B.A., R.T.(R)(T), CPC
Director, Client Services
tbedard@revenuecycleinc.com

Documentation

"Good documentation practice helps ensure that your patients receive appropriate care from you and other providers who may rely on your records for patients’ past medical histories."
Office of the Inspector General (OIG)

…but remember when a claim is submitted for services rendered to a Medicare beneficiary, the provider is essentially filing a bill with the Federal Government and certifying they have complied with the billing requirements.
**Documentation Goals**

- Accurate reflection of the patient care provided
- Specificity of diagnosis treated
- Clinically relevant documentation for other providers or clinicians
- Compliant with published rules and requirements
- Efficient workflow for completion and retrieval
- Supportive of billed charges

**Consequences of Poor Documentation**

- Quality of care and patient safety
- Departmental and staff efficiency
  - Clinical staff and physician
  - Billing, coding and reimbursement staff
- Insufficient documentation to support payments/reimbursement

*Medicare contractors perform medical reviews to ensure payment is made only for services that meet all Medicare coverage, coding and medical necessity requirements.*
MAC Reviews

- Integrity Program Manual, Ch. 3, 3.2.1
  - The MACs have the authority to review any claim at any time, however, the claims volume of the Medicare Program doesn’t allow for review of every claim. The MACs shall target their efforts at error prevention to those services and items that pose the greatest financial risk to the Medicare program and that represent the best investment of resources. This requires establishing a priority setting process to assure MR focuses on areas with the greatest potential for improper payment.

- The MACs have the discretion to select target areas because of:
  - High volume of services;
  - High cost;
  - Dramatic change in frequency of use;
  - High risk problem-prone areas; and/or,
  - Recovery Auditor, CERT, Office of Inspector General (OIG) or Government Accounting Office (GAO) data demonstrating vulnerability. Probe reviews are not required when targeted areas are based on data from these entities.

Authentication

All entries must be legible and complete, and must be authenticated and dated promptly by the person (identified by name and discipline) who is responsible for ordering, providing, or evaluating the service furnished.

The author of each entry must be identified and authenticate his or her entry.
Code of Federal Regulations
Title 21

PART 11 -- ELECTRONIC RECORDS; ELECTRONIC SIGNATURES
Subpart B--Electronic Records

Sec. 11.50 Signature manifestations.

(a) Signed electronic records shall contain information associated with the signing that clearly indicates all of the following:
(1) The printed name of the signer;
(2) The date and time when the signature was executed; and
(3) The meaning (such as review, approval, responsibility, or authorship) associated with the signature.

(b) The items identified in paragraphs (a)(1), (a)(2), and (a)(3) of this section shall be subject to the same controls as for electronic records and shall be included as part of any human readable form of the electronic record (such as electronic display or printout).

Program Integrity Manual

3.3.2.4 Signature Requirements
(Rev. 751; Issued: 10-20-17; Effective: 11-20-17; Implementation: 11-20-17)

Providers should not add late signatures to the medical record (beyond the short delay that occurs during the transcription process) but instead should make use of the signature authentication process. The signature authentication process described below should also be used for illegible signatures.

- If the signature is illegible, MACs, ZIPCs and CERT shall consider evidence in a signature log or attestation statement to determine the identity of the author of a medical record entry.

- If the signature is missing from an order, MACs and CERT shall disregard the order during the review of the claim (e.g., the reviewer will proceed as if the order was not received).

- If the signature is missing from any other medical documentation (other than an order), MACs and CERT shall accept a signature attestation from the author of the medical record entry.
Signature Requirements

• Incomplete orders may result in recoupment of payment

Complying with Medicare Signature Requirements states:


Tips & Tricks

• Label or tabulate submitted documentation
• Highlight or add comments
• Utilize appropriate verbiage and terminology
• Clear titles or headers for procedure notes
• Review all documentation for required signatures
  - Signature log if illegible
  - Attestation statement for missing signatures
  - Screen capture of EMR
Authoritative Guidance

- Federal Register
- Centers for Medicare & Medicaid Services (CMS)
- American Medical Association & CPT® Manual
- OIG Compliance Standards
- Commercial Payer Policies

Medicare Administrative Contractors

Companies awarded a bid to be the Medicare provider for a specific region of the country
- Enroll health care providers in the Medicare program and educate providers on Medicare billing requirements
- Answer provider and beneficiary inquiries
- Publish guidelines and coverage for services within Local Coverage Determinations (LCDs)
- Central point of claims processing for Part A and B
- 10 year term, then re-bid process begins
Current WPS LCDs & Articles

- Chemotherapy Drugs and their Adjuncts (L37205)
- Drugs and Biologics (Non-chemotherapy), L34741 retiring 6/10/19
- Erythropoiesis Stimulating Agents (ESAs) (L34633)
- Chemotherapy Agents for Non-Oncologic Conditions (A55639)
- Drug Administration Coding (A54176)
- Not Otherwise Classified Chemotherapy Agents (NOC) Billing and Coding Guidelines (A55640)

Medicare Claims Processing Manual

- Numerous Internet-Only Manuals (IOMs) are published and provide additional guidance
  - Chapter 1 – General Billing Requirements
  - Chapter 4 – Part B Hospital (Including Inpatient Hospital Part B and OPPS)
  - Chapter 12 - Physicians/Nonphysician Practitioners
  - Chapter 13 – Radiology Services and Other Diagnostic Procedures
  - Chapter 17 – Drugs and Biologicals
  - Chapter 22 – Remittance Advice
  - Chapter 23 – Fee Schedule Administration and Coding Requirements

National Correct Coding Initiative (NCCI)

- Developed to promote correct coding and control improper coding resulting in inappropriate payments
- Based on coding conventions defined by the CPT® Manual
- Updated Quarterly
- Practitioner versus hospital outpatient publications
- Edits include:
  - Procedure to Procedure (PTP)
  - Medically Unlikely Edits (MUE)


PTP Edits

- CPT® codes listed in either Column 1 or Column 2
- Indication:
  - 0 – Rule “zero chance of getting paid” = Modifier not allowed
  - 1 – Rule “one chance of getting paid” = Modifier allowed
  - 9 – Rule no longer applicable “typically in place originally in error”

<table>
<thead>
<tr>
<th>Column 1</th>
<th>Column 2</th>
<th>Effective Date</th>
<th>Deletion Date</th>
<th>Indication</th>
</tr>
</thead>
<tbody>
<tr>
<td>96372</td>
<td>99213</td>
<td>20031001</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>96372</td>
<td>G0463</td>
<td>20140701</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>96409</td>
<td>99211</td>
<td>20060101</td>
<td></td>
<td>0</td>
</tr>
</tbody>
</table>
Modifiers

- Two digit designation added to the end of a CPT® code, provides additional information about the billed procedure
- Classified as either:
  - Payment modifier
  - Information modifier

Modifiers 59 and X Update

Modification of the MCS Claims Processing System Logic for Modifier 59, XE, XS, XP, and XU Involving the National Correct Coding Initiative (NCCI) Procedure to Procedure (PTP) Column One and Column Two Codes, Effective July 1, 2019

NCCI Policy Manual

- Published annually
- Divided into chapters by code range
- Provides additional instruction and guidance

“2. CPT codes 96360, 96365, 96374, 96409, and 96413 describe “initial” service codes. For a patient encounter only one “initial” service code may be reported unless it is medically reasonable and necessary that the drug or substance administrations occur at separate intravenous access sites. To report two different “initial” service codes use NCCI-associated modifiers.”
Packaging vs. Bundling

- Packaging – services are not separately paid, but still reported on claim form (hospitals to CMS)
- Bundling – service is not separately paid and cannot be reported on claim form

Conditionally Packaged Administration

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>96377</td>
<td>Application of on-body injector (includes cannula insertion) for timed subcutaneous injection</td>
</tr>
<tr>
<td>96379</td>
<td>Unlisted therapeutic, prophylactic, or diagnostic intravenous or intra-arterial injection or infusion</td>
</tr>
<tr>
<td>96549</td>
<td>Unlisted chemotherapy procedure</td>
</tr>
<tr>
<td>96371</td>
<td>Subcutaneous infusion for therapy or prophylaxis (specify substance or drug); additional pump set-up with establishment of new subcutaneous infusion site(s) (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>96372</td>
<td>Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular</td>
</tr>
<tr>
<td>96401</td>
<td>Chemotherapy administration, subcutaneous or intramuscular; non-hormonal antineoplastic</td>
</tr>
<tr>
<td>96402</td>
<td>Chemotherapy administration, subcutaneous or intramuscular; hormonal antineoplastic</td>
</tr>
<tr>
<td>96405</td>
<td>Chemotherapy administration; intralesional, up to and including 7 lesions</td>
</tr>
</tbody>
</table>
Bundled Services

CPT® Manual states:
"If performed to facilitate the infusion or injection, the following services are included and are not reported separately:

a. Use of local anesthesia
b. IV start
c. Access to indwelling IV, subcutaneous catheter or port
d. Flush at conclusion of infusion
e. Standard tubing, syringes, and supplies"

Supplies

- Supplies used with administration, i.e. needles and syringes, do not qualify for separate reimbursement.
- Medicare Claims Processing Manual states: "separate payment is never made for routinely bundled services and supplies. CMS has provided RVUs (relative value units) for many of the bundled services/supplies. However, RVUs are not for Medicare payment use. Carriers may not establish their own relative values for these services."
**Prescription/Order for Treatment**

**Required:** Physician provides a completed order for chemotherapy and support medications, prior to each treatment (date of service)

- Patient name
- Name of the medication, generic/brand
- The dosage of each medication (strength)
- Method of medication administration (route)
- Sequence of administration
- Physician signature, date and time

Ensure internal policies are followed as well

---

**Basic Definitions**

**Infusion**

- Administration of diagnostic, prophylactic, or therapeutic intravenous (IV) fluids and/or drugs given over a period of time.

**Injection**

- The act of forcing a liquid into the body by means of a needle or syringe.

**Hydration**

- An administration of prepackaged fluids and/or electrolytes without drugs.
Pharmaceuticals

Divided into two categories for coding purposes

- **Complex**
  - Chemotherapy Drugs
  - Biological Drugs

- **Therapeutic**
  - Therapeutic Drugs
  - Prophylactic Drugs

---

**Complex Vs. Therapeutic**

**Complex**
- Abatacept (Orencia®)
- Bevacizumab (Avastin®)
- Cyclophosphamide (Cytoxan®)
- Docetaxel (Taxotere®)
- Infliximab (Remicade®)
- Trastuzumab (Herceptin®)
- Methotrexate (Folex®)
- Paclitaxel (Taxol®)
- Nivolumab (Opdivo®)
- Rituximab (Rituxan®)
- Fulvestrant (Faslodex®)

**Therapeutic**
- Magnesium sulfate
- Potassium chloride
- Ferric carboxymaltose (Injectafer®)
- Sodium ferric gluconate (Ferrlecit®)
- Iron dextran (Infed®)
- Anti-emetics (Zofran®, Aloxi®, Emend®)
- Lorazepam (Ativan®)
- Gammagard® (IVIG)
- Zantac®
- Dexamethasone (Decadron)
- Diphenhydramine (Benadryl®)
WPS Chemo vs. Therapeutic

The administration of the following drugs should not be billed using a chemotherapy administration code; instead, the administration of the following drugs in their subcutaneous forms should be billed using CPT codes 96372 (therapeutic, prophylactic, or diagnostic injection (specify substance or drug), subcutaneous or intramuscular). For the drugs that are administered IV the CPT codes for IV injection/infusion should be used codes 96365-96369 and 96374-96375.

<table>
<thead>
<tr>
<th>Generic Name</th>
<th>Trade Name</th>
<th>HCPCS Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>abatacept</td>
<td>Orencia®</td>
<td>J0129</td>
</tr>
<tr>
<td>bivalirudin</td>
<td>Faronys™</td>
<td>J0561</td>
</tr>
<tr>
<td>bezolotoxumab</td>
<td>Zinplava™</td>
<td>J0565</td>
</tr>
<tr>
<td>cabozintumab</td>
<td>Xcavel®</td>
<td>J0638</td>
</tr>
<tr>
<td>cetuximab pegol</td>
<td>Cremzie®</td>
<td>J0717</td>
</tr>
<tr>
<td>denosumab</td>
<td>ProLia®/Xgeva®</td>
<td>J0897</td>
</tr>
<tr>
<td>eculizumab</td>
<td>Soliris®</td>
<td>J1300</td>
</tr>
<tr>
<td>elarcea®</td>
<td>Radicava®</td>
<td>J1301</td>
</tr>
<tr>
<td>olaratumab</td>
<td>Simponi®</td>
<td>J1602</td>
</tr>
<tr>
<td>inobulinab</td>
<td>Nucala®</td>
<td>J2162</td>
</tr>
<tr>
<td>itolizumab</td>
<td>Tysabri®</td>
<td>J2353</td>
</tr>
<tr>
<td>nimotuzumab</td>
<td>Xolair®</td>
<td>J2357</td>
</tr>
<tr>
<td>pintusine</td>
<td>Cinpatro™</td>
<td>J3430</td>
</tr>
<tr>
<td>resistumab</td>
<td>Cingal®</td>
<td>J2768</td>
</tr>
<tr>
<td>rinoncept</td>
<td>Arcalyx®</td>
<td>J2793</td>
</tr>
<tr>
<td>biskizumab</td>
<td>Acelmer®</td>
<td>J5252</td>
</tr>
<tr>
<td>ustekinumab</td>
<td>Stelara®</td>
<td>J5357 for subcutaneous injection</td>
</tr>
<tr>
<td>ustekinumab</td>
<td>Stelara®</td>
<td>J5355 for intravenous injection</td>
</tr>
<tr>
<td>vedolizumab</td>
<td>Entyvio®</td>
<td>J5359</td>
</tr>
</tbody>
</table>

General Coding Guidelines

- Type of administration should be consistent with the type of drug or infusate
  - Chemotherapy or complex
  - Therapeutic, prophylactic and diagnostic
  - Hydration
- Administration should be consistent with the known routes of administration for each drug
- Separate drugs may have a separate admin. code, unless...
  - Drug(s) are in the same bag
  - Documentation does not support service
Administration Code Categories

<table>
<thead>
<tr>
<th>Initial</th>
<th>Sequential</th>
</tr>
</thead>
<tbody>
<tr>
<td>Each additional</td>
<td>Concurrent</td>
</tr>
</tbody>
</table>

Administration codes in the CPT® Manual are defined using one of these categories:

Initial Code

- One “initial” code is reported per encounter unless protocol requires two separate IV sites
  - Facility setting: based on defined hierarchy
  - Clinic/Office setting: based on the primary reason for the encounter
- Other services are reported with “sequential”, “each additional” or “concurrent” codes
  - The order in which drugs are administered does not define which code is considered “initial”
Medical Oncology Hierarchy

Key Questions

- Drug
- Route
- Time
- Site

What? How?
When? Where?
Medication Administration Record (MAR)

- Patient Name & Demographics
- Date of Service
- Name of Drug
- Start/Stop Times
- Route Used
- Nursing Signatures (including co-check)

Start & Stop Times

- **Exact** start and stop times recommended
- Recommend documenting stop times for pushes
- No rounding, estimating or approximating
- Infusion codes should not be reported per protocol
  - Variations based on individual patient tolerance
  - Over/under fill of the container
**Chemotherapy / Complex administration**

- Parenteral administration of:
  - Non-radionuclide antineoplastic drugs for cancer diagnoses
  - Anti-neoplastic agents provided for the treatment of non-cancer diagnoses
  - Monoclonal antibody agents, and other biologic response modifiers
- Highly complex services requiring **direct supervision**
- **Special consideration and training** due to preparation, dosage or disposal of the substances
- Entail significant **patient risk and frequent monitoring**

**Rule of Thumb**

- Certain pharmaceuticals are instructed to be used with chemotherapy administration codes
  - HCPCS J9000-J9999 (Chemotherapy Drugs)
  - Additional drugs considered to be complex
    - Example:
      - J1745 – Injection, infliximab (Remicade®)

Payers may provide specific coding instructions
**Push Coding Rules**

- 96411 can be reported once for each drug administered.
- Multiple pushes of the same chemotherapy drug are reported with a single unit. Example: Adriamycin® provided via 2 syringes.
- If several chemotherapy agents are mixed in a single syringe/bag and pushed together, the service is considered a single push.
- If the two drugs are administered separately in separate syringes/bags or sequentially in different syringes/bags, the push code to be reported with 2 units.

---

**Time-Based Coding**

<table>
<thead>
<tr>
<th>Infusion Time</th>
<th>Coding</th>
</tr>
</thead>
<tbody>
<tr>
<td>15 minutes or less</td>
<td>IV Push</td>
</tr>
<tr>
<td>16-90 minutes</td>
<td>Initial hour</td>
</tr>
<tr>
<td>91-150 minutes</td>
<td>Initial hour + 1 additional hour</td>
</tr>
<tr>
<td>151-210 minutes</td>
<td>Initial hour + 2 additional hours</td>
</tr>
<tr>
<td>211-270 minutes</td>
<td>Initial hour + 3 additional hours</td>
</tr>
</tbody>
</table>

Same time-based concept applies to therapeutic/prophylactic administration and hydration.
**Therapeutic, Prophylactic & Diagnostic Administration**

- Includes antibiotics, steroids, antiemetic's, narcotics, analgesics, etc.
- Typically requires:
  - Direct supervision
  - Special considerations for preparation, dosage & disposal
  - Training & competency of staff who administer
  - Periodic patient assessment

---

**Hydration**

Hydration generally consists of a prepackaged fluid and electrolytes (e.g. normal saline, D5-1/2)

When the fluid is ordered and is medically necessary; i.e. for dehydration or to prevent nephrotoxicity, it is a billable hydration

When a solution such as NS is provided as a vehicle to dilute the drug, it is considered a supply and it is NOT billable

If the physician orders the addition of electrolytes to a bag of fluid, it is considered to be a therapeutic infusion
Hydration Requirements

- Minimum of 31 minutes of hydration infusion is required to be considered billable
- Infusion times must be consecutive (sequentially), not cumulative (pre and/or post all timed drugs)
- Must be hydrating, not keeping an IV line open or flushing between drugs to be considered hydration
- Minimum of 500 ml

Billing for 340B Drugs

- Modifier required eff. 1/1/18 to identify drugs acquired under 340B Program
  - Providers not excepted to report “JG” (Drug or biological acquired with 340B Drug Pricing Program Discount) on claim
  - In alignment with Medicaid program requirements in many states already
- Drugs not acquired under 340B Program, not reported with “JG” modifier
## 340B Program Modifiers

Rural SCHs, children’s hospitals & cancer hospitals

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>TB</td>
<td>Drug or biological acquired with 340b drug pricing program discount, reported for informational purposes</td>
</tr>
</tbody>
</table>

Hospitals purchasing drugs under 340B Program

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>JG</td>
<td>Drug or biological acquired with 340b drug pricing program discount</td>
</tr>
</tbody>
</table>

---

Thank You!

TERI BEDARD, BA, R.T.(R)(T), CPC • DIRECTOR OF CODING POLICY

tbedard@revenuecycleinc.com