Coding Tips, Hints & Pointers for Medical Oncology Billing

Empire State Hematology & Oncology Society Meeting

October 5, 2018

Disclaimer

When a third-party payer is involved, the determination of reimbursement for services is the decision of the individual insurance company based on the patient’s policy and the third-party payer guidelines. No guidance can adequately address reimbursement issues for the hundreds of insurance payers that exist. Efforts have been made to ensure the information was valid at the date of presentation. Reimbursement policies vary from insurer to insurer and the policies of the same payer may vary within different U.S. regions. All policies should be verified to ensure compliance. Therefore, it is essential that each payer be contacted for their individual requirements.

The websites listed in this presentation are current and valid as of the date of this presentation. However, webpage addresses and the information on them may change or disappear at any time and for any number of reasons. The attendee is encouraged to confirm or locate any URLs listed here that are no longer valid.

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CPT® Manual

When reporting codes for services provided, it is important to assure the accuracy and quality of coding through verification of the intent of the code by use of the related guidelines, parenthetical instructions, and coding resources, including CPT® Assistant and other publications resulting from collaborative efforts of the American Medical Association with the medical specialty societies (i.e., Clinical Examples in Radiology).

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.
**Review Areas**

- Provider-based status
- Prolonged services
- Payment for drugs purchased under 340B Program
- Targeted and probe reviews for outpatient drugs
  - Neulasta® (pegfilgrastim)
  - Avastin® (bevacizumab)
  - Erbitux® (cetuximab)...
- Evaluation and Management Visits

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**OIG Work Plan**

- New 2018: Medicare Part B Drug Payments: Impact of Price Substitutions Based on 2016 Average Sales Prices
- Medicare Payments for Chronic Care Management
- Drug Waste of Single Use Vial Drugs
  - Will track the top 20 drugs utilized and billed with the JW Modifier
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
### CMS Publications

- **National Coverage Determination (NCD)**
- **Local Coverage Determination (LCD)**
- **Manuals & Transmittals**
- **National Correct Coding Initiative (NCCI)**
National Coverage Determination (NCD)

- Determination by the Secretary of the Department of Health and Human Services whether or not an item or service is covered nationally
- Examples:
  - National Coverage Determination for Erythropoiesis Stimulating Agents (ESAs) in Cancer and Related Neoplastic Conditions (110.21)
  - Aprepitant for Chemotherapy-Induced Emesis (110.18)
- In absence of an NCD, Medicare contractors may establish an LCD

Local Coverage Determination (LCD)

- Carrier, fiscal intermediary or MAC develop and/or adopt LCDs to define whether a particular service will be covered
- Developed when no NCD is published or in need of further definition
- May include:
  - CPT® and HCPCS coding instructions
  - ICD-10 codes
  - Documentation requirements
  - Associated articles with additional instructions
Retired LCDs

• Policies remain active when there is evidence of significant problems with performance, billing and/or coding
• Correct claims submission is expected with or without an active LCD

Find Your Policies

Current NGS LCDs & Articles (just a few)

- Drugs and Biologicals, Coverage of, for Label and Off-Label Uses, L33394
- Hospice - Determining Terminal Status, L33393
- Bevacizumab (e.g., Avastin™) - Related to LCD L33394, A52370
- Bortezomib (e.g., Velcade®) – Related to LCD L33394, A52371
- Clinical Trials – Medical Policy Article, A52840
- Drugs and Biologicals, Coding Article, A52855
- Filgrastim, Pegfilgrastim (e.g., Neupogen®, Neulasta TM) - Related to LCD L33394, A52408

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>
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<td>96372</td>
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<td>20140701</td>
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</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

25 - E&M /procedure on same day
Q0 – Investigational clinical services
Q1 – Routine standard of care services
S9 – Distinct Procedural Service
EA – Chemotherapy induced anemia
EC – Non-chemo/radio induced anemia

X Modifiers

XE Separate Encounter, A Service That Is Distinct Because It Occurred During A Separate Encounter
XS Separate Structure, A Service That IS Distinct It Was Performed On A Separate Organ/Structure
XP Separate Practitioner, A Service That Is Distinct Because It Was Performed By A Different Practitioner
XU Unusual Non-Overlapping Service, The Use Of A Service That Is Distinct Because It Does Not Overlap Usual Components Of The Main Service

Developed to provide greater reporting specificity in lieu of modifier S9 when possible.
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:

- **Use of local anesthesia**
- **IV start**
- **Access to indwelling IV, subcutaneous catheter or port**
- **Flush at conclusion of infusion**
- **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."

Z Codes

• An exception to the ICD-10 coding sequence occurs when the sole purpose of the patient visit is for chemotherapy or immunotherapy
• In this case, apply the appropriate "Z" code(s), as the primary code(s) followed by the malignancy diagnosis
  – Z51.11 (Encounter for antineoplastic chemotherapy)
  – Z51.12 (Encounter for immunotherapy)
Chemotherapy Vs. Immunotherapy

<table>
<thead>
<tr>
<th>Chemotherapy (Z51.11)</th>
<th>Immunotherapy (Z51.12)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doxorubicin (Adriamycin*)</td>
<td>Bevacizumab (Avastin*)</td>
</tr>
<tr>
<td>Pemetrexed (Alimta*)</td>
<td>Ofatumumab (Arzerra*)</td>
</tr>
<tr>
<td>Bleomycin (Blenoxane*)</td>
<td>Cetuximab (Erbitux*)</td>
</tr>
<tr>
<td>Carboplatin (Paraplatin*)</td>
<td>Pembrolizumab (Keytruda*)</td>
</tr>
<tr>
<td>Decitabine (Dacogen*)</td>
<td>Ipilimumab (Yervoy*)</td>
</tr>
<tr>
<td>VP-16, Etoposide phosphate</td>
<td>Nivolumab (Opdivo*)</td>
</tr>
<tr>
<td>5-FU, 5-Flourouracil</td>
<td>Panitumumab (Vectibix*)</td>
</tr>
<tr>
<td>Topotecan (Hycamtin*)</td>
<td>Rituximab (Rituxan*)</td>
</tr>
<tr>
<td>Oxaliplatin (Eloxatin*)</td>
<td>Trastuzumab (Herceptin*)</td>
</tr>
</tbody>
</table>

Long Term Drug Therapy

- **Z79.810** Long term (current) use of selective estrogen receptor modulators (SERMs)
  - *Ex. Evista*, *Nolvadex* (tamoxifen) and *Fareston*
- **Z79.811** Long term (current) use of aromatase inhibitors
  - *Ex. Arimidex*, *Aromasin* and *Femara*
- **Z79.818** Long term (current) use of other agents affecting estrogen receptors and levels
  - *Ex. Faslodex*, *Zoladex*, *Lupron*, *Megace*
**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

**Signature Requirements**

- Incomplete orders may result in recoupment of payment

Complying with Medicare Signature Requirements states:

Infusions & Injections

**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

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**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®)
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

- Initial
- Sequential
- Each additional
- Concurrent

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

- Chemotherapy / Complex Infusion
- Chemotherapy / Complex IV Push
- Therapeutic / Prophylactic Infusion
- Therapeutic / Prophylactic IV Push
- Hydration
**Key Questions**

- **What?**
- **How?**
- **When?**
- **Where?**
- **Drug**
- **Route**
- **Time**
- **Site**

**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**
Drug Classification Examples

- Alkylating agents attach directly to DNA, stopping the strand from uncoiling and dividing (Cytoxan®, Ifosfamide)
- Alkylating like agents (Carboplatin, Oxaliplatin)
- Monoclonal antibodies (Herceptin®, Rituxan®)
- Targeted agents, which inhibit growth by binding to specific cells (Avastin®, Erbitux®)
- Hormonal antineoplastic (Lupron®, Faslodex®)

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

Concurrent Infusion CPT® 96368

Simultaneous infusion of two non-chemotherapy drugs or a therapeutic drug and a chemotherapy drug prepared in separate solutions and are hung in separate bags

Reported by the hospital although there is currently no separate reimbursement for this service under OPPS

If all of the drugs are chemotherapy drugs utilize CPT® 96549 (unlisted chemotherapy procedure)
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>
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</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