Medical Oncology Coding Update

Hawaii Society of Clinical Oncology
Honolulu, HI
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Objectives

Discuss the Importance of Compliance

Provide Overview of 2014 Final Rule

Identify Specific Guidelines for Documentation

Understand Coding and Billing Guidelines for Services
Our Policy:

RCI adheres to the following policy when providing services and recommendations:

• We will be consistent with published Medicare guidelines
  • Local Coverage Determinations
  • CPT® definitions and advice from AMA
  • CCI/OCE Edits
• We will utilize published OIG compliance standards
• When Medicare guidelines are not present we will utilize acceptable standards of care in Medical Oncology
  • ASCO American Society of Clinical Oncology
  • ACCC Association of Community Cancer Centers
  • NCCN Clinical Practice Guidelines in Oncology
  • ONS Oncology Nursing Society

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Disclaimer

This presentation was prepared as a tool to assist attendees in learning about documentation, charge capture and billing processes. It is not intended to affect clinical treatment patterns. While reasonable efforts have been made to assure the accuracy of the information within these pages, the responsibility for correct documentation and correct submission of claims and response to remittance advice lies with the provider of the services. The material provided is for informational purposes only.

Efforts have been made to ensure the information within this document was accurate on 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.

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Medical Necessity

- Per Medicare, services provided must be to treat illness or injury or improve functioning of malformed body member
- Services must be consistent with generally accepted professional medical standards
- Furnished at the most appropriate level that can be provided safely and effectively
How Does Medicare Affect Oncology

- Documentation Guidelines
- Development of rules/requirements for Electronic Health Record (EHR)
- Signature Guidelines
- Claims processing
- Fees for service
- Drugs (Average Sales Price/Not Otherwise Classified)
- Designates procedures and/or quantities reported on a single date of service
Local Coverage Determinations

- LCDs are published guidelines & requirements for coverage under Medicare
- Determines if services are indicated or necessary
- Provide statutory provisions:
  - Documentation requirements
  - Medical necessity
  - Coverage for services
  - Coding instructions
  - Jurisdiction only within regional area
Commercial (Non-Medicare)

- May develop their own policies
- May not follow Medicare guidelines
- Policies are specified in private contracts between the payor and the practice or provider
To Access Policies

- Navigate the Medicare website at www.cms.hhs.gov
- Choose Medicare
- Choose Medicare Coverage Determination Process
- Choose Local Coverage Determinations
- Choose specific method for your search by Contractor or by State

Don’t forget to look for attachments!
COMPLIANCE......

You can’t close your eyes to it.....

Or stick your head in the sand!
Billing/Documentation Compliance

• Required, not an OPTION
• Assists in maintaining current Policies & Procedures
• May prove vital in the event of outside review by Medicare, OIG, or any other payer

A Formal Compliance Plan (IF followed):
• Demonstrates the provider’s plan in accordance with the rules
• Documents how you will address non-compliance
• Provides an audit schedule for internal & external chart reviews
• Details policy for clear, concise, legible documentation &/or EMR processes
• Ensuring HIPAA

OIG has Compliance Guidelines:
Be Prepared

• Conduct an internal assessment to identify if you are in compliance with Medicare rules
• Identify corrective actions to promote compliance
• Appeal when necessary
• Learn from past experiences: know where previous improper payments have been found:
  – Demonstration findings: [www.cms.hhs.gov/rac](http://www.cms.hhs.gov/rac)
  – OIG reports: [www.oig.hhs.gov/reports.html](http://www.oig.hhs.gov/reports.html)
  – CERT reports: [www.cms.hhs.gov/cert](http://www.cms.hhs.gov/cert)
OIG Methodology

METHODOLOGY
Our review covered FYs 2010 through 2012. We based our review on an analysis of data from seven sources: (1) a review of policies and procedures and documentation of the Unit’s operations, staffing, and caseload; (2) a review of financial documentation; (3) structured interviews with key stakeholders; (4) a survey of Unit staff; (5) structured interviews with the Unit’s director and supervisors; (6) an onsite review of case files that were open in FYs 2010 through 2012; and (7) an onsite review of Unit operations. We analyzed data from all seven sources to describe the caseload; assess the performance of the Unit; identify any opportunities for improvement; and identify any instances in which the Unit did not fully meet the performance standards or was not operating in

- The areas/staff the OIG reviews, during an audit
OIG Excerpts

- “The Unit did not have policies and procedures specific to its operations
- According to Performance Standard 3, the Unit should establish policies and procedures for its operations.”
- The OIG findings report continues with staff training
  - Including money allocated for training
  - Time allocated for training

- 2013 Onsite Review (OEI-06-12-00720)
So What’s On The Radar?

- Professional Services
- Physician Supervision
- Provider Signatures
- Medical Necessity
- Place of Service Coding
- IV Hydration
- Neulasta
- Initial Infusion services
Example of E & M

Figure 2. The Number of E/M Services Rendered for Established Beneficiaries by You and the Average Number of E/M Services Rendered for Established Beneficiaries by Your State and National Peers per CPT Code

- 99211: You - 32.0, State - 28.8, Nation - 27.3
- 99212: You - 36.0, State - 42.2, Nation - 41.5
- 99213: You - 35.9, State - 36.2, Nation - 41.0

- Reference CERT example provided on Safeguard site
Supervision

History

• In the CY 2000 OPPS final rule, CMS indicated that direct supervision is the standard for all hospital outpatient therapeutic services covered and paid by Medicare in hospitals and in provider-based departments (PBDs) of hospitals

• CMS stated since outpatient services are furnished “incident to” a physician’s professional service, they believe conditions for payment, including the direct supervision standard should apply to services
Supervision

The final rule continues to state the supervisory responsibility is more than the mere capacity to respond to an emergency

- Includes being able to reassess the patient & potentially modify treatment as needed on a nonemergency basis
- Includes the ability to redirect or take over performance of the service & to issue any additional necessary orders
- Appropriate supervision must be provided by a provider clinically trained in the specialty for which they are supervising
- Must have within their state Scope of Practice the ability to provide the services in which they are supervising
Signature Requirements

PROTECTING THE MEDICARE TRUST FUND

IOM - Medicare Program Integrity Manual, Pub. 100-08
http://www.cms.gov/Manuals/IOM/list.asp

Chapter 1 of this manual provides an overview of the Medical Review (MR) and Medicare Benefit Integrity (BI) Programs. Chapter 3 of this manual outlines the importance of signatures, specifically for all medical review purposes related to medical records and electronic prescribing. Chapter 3 also includes guidance for Medicare Contractors on Clinical Review Judgment (CRJ). Other chapters in the Program Integrity Manual (PIM) reflect the principles, values, and priorities for the Medicare Integrity Program (MIP), whose primary principle is to protect the Medicare Trust Fund from fraud, waste, and abuse.

FAST FACT: Signatures

Chapter 3 of Pub. 100-08 requires that services provided/ordered be authenticated by the author. The method used shall be handwritten or an electronic signature. Stamped signatures are not acceptable.
As Stated by Medicare............

“All entries in the medical record must be dated, timed, and authenticated, in written or electronic form, by the person responsible for providing or evaluating the service provided.

When State law and/or hospital policy requires that entries in the medical record made by residents or non-physicians be countersigned by supervisory or attending medical staff members, then the medical staff rules and regulations must address counter-signature requirements and processes.”
Signature Requirements

Updated June 2010

Written Signatures

- Full name or first initial and last name
- Legible or accompanied by signature log
- Date and time

Electronic Signatures

- Provided via secure login and password
- Printed statement
- Name, credentials, date and time
- Medicare example:

  "Electronically Signed By: John Doe, M.D. 08/01/2011 @ 06:26pm"
WHAT WAS THAT CODE ????????
Diagnosis Accuracy

- The proper diagnosis must be established from the beginning (only the physician can assign a diagnosis)
- Payment for your entire treatment may depend on it – determine if the patient’s treatment is approved for the patient’s condition and verify the diagnosis against the pathology report
- Establish an off-label policy when the treatment is for an unapproved diagnosis

For example, when a chemotherapy drug is approved for treating one type of cancer, but is used to treat a different cancer, it is off-label use.
ICD-9-CM Diagnosis Hierarchy

• Treatment directed at the malignancy is the primary diagnosis. It is coded to the highest level of specificity.

• Treatment directed at the secondary malignancy is the primary diagnosis and the principal malignancy is listed second.

• Complications associated with the malignancy may be the primary code if it is being treated in relation to the malignancy and managed by the oncologist.
When to apply a V code

• An exception to the ICD-9 coding sequence occurs when the sole purpose of the patient visit is for chemotherapy.

• In this case, you would apply the appropriate V code, V58.11 (Encounter for antineoplastic chemotherapy), as the primary code followed by the malignancy diagnosis.

• V & E codes are payor specific
ICD-10 Background


- The Centers for Disease Control (CDC) is the organization who has developed a clinical modification of the classification for the morbidity purposes.

- The US Department of Health and Human Services (HHS) has mandated the replacement of the ICD-9-CM code sets used by medical coders and billers to report health care diagnoses and procedures with ICD-10 codes, effective date of October 1, 2014. ICD-10 implementation will radically change the way coding is currently done and will require a significant effort to implement.

- ICD-10-CM was developed by the Centers for Disease Control and Prevention for use in all U.S. health care settings. Diagnosis coding under ICD-10-CM uses 3 to 7 digits instead of the 3 to 5 digits used with ICD-9-CM, but the format of the code sets is similar.
ICD-10 LCD’s and Articles

- ICD-10/Article Plan
  - Identify current systems and processes that utilize ICD-9; to incorporate ICD-10
  - Establish a process to review current LCD’s
  - Identify and coordinate staff to ensure continuity with expected changes
  - April 10, 2014 updates to current LCD’s and Articles on Medicare Coverage Database
  - September 4, 2014 final update to MCD
Who Needs Training?

- Clinicians (Physicians, PA’s, NP’s)
- Nursing staff
- HIM staff
- Department managers
- Registration staff
- Billing and Coding staff
- EHR staff (Information Technology)
How to begin preparing

• Project Plan
  – Review current systems and processes that utilize ICD-9
  – Establish a budget for the conversion
  – Coordinate with vendors, payers…
  – Identify work flow changes
  – Train staff
  – Testing
One-to-Three Mapping

ICD-9-CM

175.0
Malignant neoplasm nipple & areola
male breast

ICD-10-CM

C50.021
Malignant neoplasm nipple & areola,
right male breast

C50.022
Malignant neoplasm nipple & areola,
left male breast

C50.029
Malignant neoplasm nipple & areola,
unsp. male breast
Neoplasm/Anemia

- ICD-9 guidelines state that your first-listed code should be for anemia, 285.22 (*Anemia in neoplastic disease*). Then, the guidelines instruct you to report the appropriate malignancy code(s).

- ICD-10 guidelines, on the other hand, instruct you to report the malignancy first and then the anemia code, D63.0 (*Anemia in neoplastic disease*).
Laterality

- C50.1 Malignant neoplasm, of central portion of breast
- C50.112 Malignant neoplasm of central portion of left female breast
- C50.111 Malignant neoplasm of central portion of right female breast
History of...

The codes corresponding to ICD-9-CM V codes (Factors Influencing Health Status and Contact with Health Services) and E codes (External Causes of Injury and Poisoning) are incorporated into the main classification rather than separated into supplementary classifications as they were in ICD-9-CM.

- **V10.3- History of Breast Malignancy**
  - Z85.3-Personal history of malignant neoplasm of Breast

- **V16.42-Family History Prostate Malignancy**
  - Z80.42-Family history of malignant neoplasm of Prostate
Aftercare with ICD-10

V58.11-Antineoplastic Chemotherapy Encounter

- Z51.11-Encounter for Antineoplastic Chemotherapy

V58.12-Immunotherapy Encounter

- Z51.12-Encounter for Antineoplastic Immunotherapy

V58.0-Radiotherapy Encounter

- Z51.0-Encounter for Antineoplastic Radiation Therapy
A Glimpse At Skin With ICD-10

172.0 Lip
- C43.0 Malignant melanoma of lip
- C03.0 Melanoma in situ of lip

172.1 Eyelid, including canthus
- C43.10 Malignant melanoma of unspecified eyelid, including canthus
- D03.10 Melanoma in situ of unspecified eyelid, including canthus
- D03.11 Melanoma in situ of right eyelid, including canthus
- D03.12 Melanoma in situ of left eyelid, including canthus

172.5 Trunk, except scrotum
- C43.59 Malignant melanoma of other part of trunk
- D03.51 Melanoma in situ of anal skin
- D03.52 Melanoma in situ of breast (skin) (soft tissue)
- D03.59 Melanoma in situ of other part of trunk

ICD-10 includes in situ codes
Evaluation and Management

- Physician evaluation and management continues to be an area of concern
  - New and Established
  - Coding by time
  - Signature Requirements
- The following definition clarifies between new and established evaluation and management
- September 10, 2013 updated CMS guidelines regarding elements 1995 combined with 1997
Definition of New and Established Patient

The AMA clarified the definitions. CPT 2013 includes the following language: "Solely for the purposes of distinguishing between new and established patients, professional services are those face-to-face services rendered by a physician and other qualified health care professionals."

- A new patient is one who has not received any professional services from the physician or another physician of the exact same specialty and subspecialty who belongs to the same group practice within the past three years.”

- An established patient is one who has received professional services from the physician or another physician of the exact same specialty and subspecialty who belongs to the same group practice within the past three years.
Coding By Time

In cases where counseling and coordination of care dominates (more than 50%) of the physician / patient and/or family encounter (face-to-face), time is considered the key or controlling factor to qualify for a particular level of E/M services.

1. Total length of time of the face-to-face encounter should be documented
2. Record *must* state that more than 50% of time was spent in counseling and/or coordination of care
3. Record should describe the counseling and/or the activities performed to coordinate care
2014 CPT Examples

- 99214 Example: Weekly visit for 5FU therapy, metastatic colon cancer, with increasing shortness of breath
  - History: Detailed, Exam: Moderate, MDM: Moderate to high (25 minutes)

- 99215 Example: Restaging of an established patient, with questionable lymph node involvement, after 1 year post treatment
  - History: Comprehensive, Exam: High, MDM: Moderate to High (40 minutes)
Clinic Visits
(Technical)

Hospitals ONLY
• Borrow professional codes until CMS develops specific
  - New Patient (99201-99205)
  - Established Patient (99211-99215)
• Professional and technical coding may differ
• CMS states:

“A patient who has been registered as an inpatient or outpatient of the hospital within the 3 years prior to a visit would be considered to be an established patient for that visit, while a patient who has not been registered as an inpatient or outpatient of the hospital within the 3 years prior to a visit would be considered to be a new patient for that visit.”
Coding Guidelines

Per CMS Instruction:

• Develop internal hospital guideline
• Relate the intensity of hospital resources to the different levels of codes
  ➢ Point system
  ➢ Staff intervention
  ➢ Staff time
• Encouraged MAC, FI and RAC auditors to review internal guidelines in the event of an audit
Clinic Visits Proposed Rules 2014

- Discontinue the current use of 99201-99205 and 99211-99215 and emergency department visits
- Proposing to create alphanumeric Level II HCPCS codes
  - Clinic visit: GXXXC: APC 0634
    - Describes all levels of clinic visits (99201-99215)
    - No longer recognizes a distinction between new and established patients
  - Type A ED visit: GXXXA: APC 0635
  - Type B ED visit: GXXXB: APC 0636
Financial Counseling

• Discussion with the patient will enable the financial counselor to assist with financial needs.
• Insurance providers may require pre/prior authorization before treatment starts.
• Under insured or uninsured patients will require the financial counselor to seek resources to assist the patient to meet financial obligations.
Drug Reimbursement Information

Published payer guidelines are very clear on the indications for chemotherapeutic drugs:

• Most payers state the drug must be reasonable and necessary for the diagnosis or treatment of illness or injury
• In some cases, the specific drug is listed along with the acceptable diagnosis codes for which that drug is approved
• Indicating that the drugs must have FDA approval for utilization on patients, etc.
• And of course, they indicate that the drugs must be reasonable and necessary for the individual patient
Drug Reimbursement MPFS

When reimbursing for drugs:

• Average Sales Price (ASP)
  – Medicare reimburses 106%
  – Fee Schedules updated quarterly
  – Subscribing to this Medicare update is beneficial to remain current on this information

• Not Otherwise Classified (NOC)
  – No reimbursement established
  – Recommend “carve outs” in contract negotiations for NOC drugs
ASP Methodology

Utilization of several sources of data as a basis for payment

ASP (average sales price)

WAC (wholesale acquisition cost)

AWP (average wholesale price)

The final rule indicates the term ASP methodology and ASP-based are inclusive of all data sources
Drug Reimbursement Regimen

(Example BSA 1.72)  MPFS  HOPPS
FOLFOX-6 for Colorectal
Oxaliplatin 172mg
5FU 688mg
5FU 4128mg
Leucovorin 688mg
Drug Reimbursement Regimen

(Example BSA 1.72)  
Carboplatin + Taxol for Lung  
Carboplatin AUC 6 = 550mg  
Taxol 200mg/m2 = 344mg  
Alimta 500mg/m2 = 860mg

TC for Breast  
Taxotere 75mg/m2 = 129mg  
Cytoxan 600mg/m2 = 1032mg
Advanced Beneficiary Notice

- Appropriately obtain ABN’s for Medicare patients if treatment is likely to be denied, i.e. B12
- Must be date specific
- Must be treatment specific
- Indicate the reason the treatment is likely to be denied
- Indicate the cost of the treatment

**May 2012 Medlearn Matters ABN:**

- A single ABN for an extended course of treatment remains valid for no more than 1 year
- If the extended course of treatment continues after a year’s duration, you must issue a new ABN
Drug Reimbursement

- Medicare reimbursement for drugs is based on billable units as quantified by the amount provided to the patient

- Other payers may choose to reimburse based on price & cost negotiations
Pass-through Status

- December 31, of each year drugs and biologicals expire from pass-through status (2014 = 15)
- Means they have an assigned code with assigned billing units
  - J0000 Name 1mg
  - J0000 Name 1mg
**Single Dose Vial vs. Multi Dose Vial**

**Single use vials**
Vial that has a volume for administration to one patient. The amount of drug given and the amount discarded must be documented as drug waste.

**Multi use vials**
Vials for use of multiple patients. Medicare does not require the drug wasted to be documented for multi use vials.
Utilization of SDV

• RCI recommends development of a single dose vial policy and procedure be developed and implemented to achieve documentation and utilization of drug waste.
• However, before considering or implementing process, sites are encouraged to review the Memorandum Summary and “USP<797>”.

Drug Waste Documentation

• When utilizing single dose vials (SDV), if drug is not utilized on another patient, the waste must be documented

• Two methods of documentation are:
  - Individual patient record
  - Drug Waste log in the pharmacy
Modifier JW

- Payor dependent, Noridian requires JW modifier
- JW drug amount discarded/not administered to patient (carriers vary, may or may not be required)
  - Option A: require drug given to patient to be split into two lines on claim – one for drug rec’d and one for wasted amount
  - Option B: total drug amount on one line with JW
- JW is NOT used for claims billed when drug code includes amount administered along with amount wasted (J2175 100 mg Demerol® 75 provided, 25 mg wasted = quantity of one – no modifier)
LCA Least Costly Alternative

• The LCA has not been eliminated. This policy allows Medicare to reimburse for a drug that is clinically as effective but less expensive.

• Example:
  ➢ If the patient is charged for Lupron®, Medicare will often reimburse the Zoladex® rate unless the physician can indicate the reason the Lupron® injection must be utilized
Drug Administration
Drug Coding Guidelines

Type of administration should be consistent with the type of drug (chemotherapy drug = chemotherapy administration) Example: IV Leucovorin is not reported with chemo admin but rather therapeutic drug admin

Each separate drug must have a separate administration, unless the drug(s) are in the same bag

The administration must be consistent with the known routes of administration – drug specific
Drug Administration Codes

Hierarchy of drugs is as follows (to establish the “initial” code):

1. **Chemotherapy Drug Administration**
2. **Therapeutic, Prophylactic and Diagnostic Services**
3. **Hydration Services**

**Drug administration codes do not correlate with the chemotherapy administrative procedural order**
Drug Administration Codes

Hierarchy of services is as follows:

1. Infusions
2. Pushes
3. Injections
Colon Drug Administration Coding

FOLFOX 6 = Oxaliplatin 100mg/m2, IV infusion over 2 hours, 5-FU 400mg/m2 IVP over 7 minutes, 5-FU 2400mg/m2 continuous infusion over 46 hours, Leucovorin 400mg/m2 IV infusion concurrently with Oxaliplatin every 14 days

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Start & Stop Times

- There are no CPT® code description changes for 2014
- Exact start and stop times are required and must be documented
- No rounding, estimating or approximating
Questions?

For questions about this presentation or our services you may contact us at 512-583-2000 or email us at info@revenuecycleinc.com
Resources

• www.accc-cancer.org
• www.asco.org
• Drug Reimbursement
• Supplies
• ICD-9 CM