

BILLING & CODING MEDICAL ONCOLOGY

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Objective:

By the end of the session,
participants will be able to...

- ... describe how HCPCs codes are used to bill drugs
- ...identify steps in choosing the correct drug administration code
- ...understand importance of accurate documentation



Medicare Sanctioned Coding Guidelines

- Written Medicare Policy including
 - National Coverage Determination (NCD)
 - Local Coverage Determination (LCD)
- Medicare article
- AMA CPT Statement
- AMA CPT Assistant statement
- AHA Coding Clinic statement



Important Articles

- **CPT[®] Assistant 3 Part Series on Drug Administration:**
 - Part 1: May 2007 Volume 17, Issue 5
 - Part 2: June 2007 Volume 17, Issue 6
 - Part 3: September 2007 Volume 17, Issue 9
- **Coding clarification on hydration:**
 - June 2008, Volume 18, Issue 6
- **AMA's CPT Changes: An Insider's View 2006**
 - Detailed description of drug/fluid administration coding rules



Billing Drugs

- Correct billing for drugs is crucial:
 - Drugs represent the largest expense to the practice
 - Drugs represent the greatest financial risk to the practice
- Drugs are reimbursed by ICD-10-CM diagnosis
- FDA Approved
 - Reimbursed if medically necessary
 - Off-Label under certain circumstances
- Clinical
 - Treatment decisions
 - Change is constant – new drugs, new indications for old drugs
 - Documentation must support the use of the drugs



J-codes

- J-codes are used for billing most Part B drugs
- Each J-code based on particular quantity
 - J9201 = Gemcitabine 200 mg
- If the amount administered exceeds the J-code quantity, bill multiple units
 - 1600 mg Gemcitabine = 8 units J9201
- If the amount administered falls between J-code units, round up
 - 1440 mg Gemcitabine given = 8 units J9201



J-codes

- Sometimes the billing unit = dose
 - J9040 Bleomycin 15 units
- Sometimes there is no relationship to dose
 - J9263 Oxaliplatin 0.5 mgs
- Vial sizes and billing units vary
 - Important to understand when new drugs are introduced



Documenting Drugs

- Documentation of drugs and biologicals in the medical record:
 - Name of drug
 - Date administered
 - Time administered (for time based codes)
 - Amount given (Gm, mg, mcg, IU, etc.)
 - Route (intravenous, intramuscular, etc.)
 - Site of the injection
 - Name and credentials of person administering the drug

When a portion of the drug is discarded, the medical record must clearly document the amount administered and the amount wasted.

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Documenting Drugs

- Documentation must show medical necessity
 - Diagnoses specific to drugs/services
- Documentation must support use - if anything differs from the package insert:
 - Dose
 - Frequency
 - Route of administration
 - Length of administration
 - Use of supportive care drugs i.e., antiemetics



Drug Quantities

- Single dose vials
 - Bill the entire amount of vial even if all the drug is not administered to the patient – *as long as the remainder of the vial is discarded and properly documented in the medical record.*
- Multiple dose vials
 - Bill for amount used
 - Round up to nearest billing unit
 - 120 mg given on 100 mg code - round to quantity 2



Wasted Drug

If after administering a dose/quantity of the drug or biological to a Medicare patient, a physician, hospital or other provider must discard the remainder of a single use vial or other single use package, the program provides payment for the amount of drug or biological administered and the amount discarded, up to the total amount of the drug or biological as indicated on the vial or package label.

Multi-use vials are not subject to payment for discarded amounts of drug or biological.

Medicare Claims Processing Manual Chapter 17 - Drugs and Biologicals, 40 - Discarded Drugs and Biologicals



Intentional Overfill

CMS clarified that “overfill”, including overfill pooled from more than one container, should not be billed to Medicare:

“Payment for amounts of free product, or product in excess of the amount reflected on the FDA approved label, will not be made under Medicare.”

Coverage policy does not prohibit the use of overfill

Medicare Physician Fee Schedule Final Rule 2011



Billing Wasted Drug

- Effective January 1, 2017, CMS requires the use of the modifier JW to identify unused drugs or biologicals from single use vials or single use packages that are appropriately discarded.
- This modifier, billed on a separate line, will provide payment for the amount of discarded drug or biological.
- For example, a single use vial that is labeled to contain 100 units of a drug has 95 units administered to the patient and 5 units discarded. The 95 unit dose is billed on one line, while the discarded 5 units shall be billed on another line by using the JW modifier. Both line items would be processed for payment. Providers must record the discarded amounts of drugs and biologicals in the patient's medical record.

Medicare Claims Processing Manual Chapter 17 - Drugs and Biologicals, 40
- Discarded Drugs and Biologicals



Wasted Drug - CMS

Do not use the JW modifier when the actual dose of the drug administered is less than the billing unit. For example:

The billing unit for a drug is equal to 10mg of the drug in a SDV. A 7mg dose is administered & 3mg of the remaining drug is discarded. The 7mg dose is billed using one billing unit that represents 10mg on a single line item.

The single line item of 1 unit is processed for payment of the total 10mg of drug administered and discarded.

Billing another unit on a separate line item with the JW modifier for the discarded 3mg of drug is not permitted because it would result in overpayment.

Therefore, when the billing unit is equal to or greater than the total actual dose and the amount discarded, the use of the JW modifier is not permitted

www.cms.gov/manuals/downloads/clm104c17.pdf



CMS FAQs – Discarded Drug Documentation

- **Q14.** Does CMS have specific requirements regarding documentation for discarded drugs, such as who is required to document the amount that is discarded, the format for whether calculated values are acceptable, or where the documentation should be kept? Is there a specific area in the medical record where the administered/discarded amount should be documented?
- **A14.** CMS expects that providers and suppliers will maintain accurate (medical and/or dispensing) records for all beneficiaries as well as accurate purchasing and inventory records for all drugs that were purchased and billed to Medicare. Providers and suppliers should also check with the MAC that processes their Part B drug claims in case additional information on billing and documentation is available at the local level.
- **Q15.** Will CMS accept an “automatic” calculation of waste, for example a calculation done by software, as documentation of waste within the medical record?
- **A15.** As long as the amount of wastage is accurately documented, the CMS does not dictate how it is calculated.



New Drugs

- Can take many months for new drug to get J-code
- For new drugs – without an assigned J-code, use the not otherwise classified (NOC) codes:
 - Chemotherapy - use J9999
 - Non-chemo drugs use - J3490
 - Biologics Use – J3590
 - C9399 - Unclassified drugs or biologicals – *may be used in the HOPD setting*
 - Verify the units to be billed on a claim for a new drug (J9999, J3490 or J3590)
 - Use comment box (box 19) to indicate generic name, amount utilized, NDC number



DRUG ADMINISTRATION

Categories & Descriptions



5 Steps to Coding Drug Administration

1. Code Category (type of drug/fluid)
2. Initial Code
3. Type of Administration Code (how the drug was administered)
4. Sequence of Administration (concurrent, sequential)
5. Length of Administration (time)



1. Code Category

To determine code category
identify drugs/fluids given:

- Chemotherapy
- Therapeutic/diagnostic drugs
- Hydration



Drug Administration Categories

- **Chemotherapy administration includes:**
 - Certain monoclonal antibodies & other biologic response modifiers
 - Anti-neoplastic agents provided for the treatment of non-cancer diagnoses
- **Therapeutic, prophylactic, and diagnostic injections and infusions** i.e., growth factors, antiemetics
- **Hydration**
 - Use for prepackaged fluids and electrolytes



Chemotherapy Drugs

- CPT codes 96401-96549 describe administration of chemotherapy or other highly complex drug or biologic agents such as certain:
 - Monoclonal antibody agents
 - Biologic response modifiers
- CPT does not designate which drugs/agents are to be reported using these codes – they provide guidance as to the type of preparation, staff, risk, monitoring, and interventions that are typical of these drugs.
- CMS does not identify which drugs/agents are to be reported using these codes.
- In general, chemotherapy drugs are those in the range of codes J9000-J9999. Certain other highly complex drugs may be billed with chemotherapy administration codes even though they have a J-code outside of the chemotherapy range of codes.



Therapeutic Drugs

- CPT codes 96365-96379 & C8957 describe therapeutic or diagnostic injections and infusions of non-chemotherapeutic drugs.
- Examples:
 - Leucovorin
 - Anti-emetics
 - Growth factors



Hydration

- CPT codes 96360-96361 describe administration of hydration including pre-packaged fluids and electrolytes (eg, normal saline, D5W etc.).
- Bill hydration services:
 - When it is the only service performed during a patient encounter, or when performed before or after drug chemo/therapeutic administration
 - When it is medically necessary
 - When hydration infusion exceeds 30 minutes
- Use modifier -59 to indicate a “distinct procedural service”
- Do not separately report the administration of fluids used to maintain patency of an access device, or fluids used to administer drugs.



2. Initial Code – Physician Office

- To determine initial code identify primary reason for the patient encounter:
 - Chemotherapy
 - Therapeutic/diagnostic drugs
 - Hydration



2. Initial Code – Facility HOPD

In the facility setting the initial code is determined by hierarchy.

Chemotherapy services are primary to therapeutic, prophylactic and diagnostic services which are primary to hydrations:

- Chemotherapy
- Therapeutic/diagnostic drugs
- Hydration

Infusions are primary to pushes which are primary to injections:

- Infusion
- IV push
- Injection



Initial Codes

- Initial service codes:
 - CPT codes 96360, 96365, 96374, 96409 and 96413
- For a patient encounter only one initial service code may be reported unless:
 - Protocol requires that two separate IV sites must be used, or
 - If the patient returns for a separate and medically reasonable visit/encounter on the same day.
- To report two initial service codes use the applicable NCCI modifier



3. Type of Administration

- To determine the type of administration code identify how each drug/fluid was given:
 - IV infusion (*short infusions of 15 min. or less billed as IV push*)
 - IV push
 - SC/IM injection



IV Push

- Intravenous or intra-arterial push:
 - An injection in which the healthcare professional who administers the substance/drug is continuously present to administer the injection and observe the patient, or
 - An infusion of 15 minutes or less.
- Do not use IV push codes for port access or “pushing” a drug into IV bag to drip intravenously



4. Sequence of Administration

- Whether drugs/fluids are infused concurrently – at the same time *or*
- Sequentially – after a previous drug/fluid infusion



Concurrent Infusions

- Use the concurrent infusion code when two drugs are administered at the same time
 - One of the drugs must be a non-chemo drug
- Only one concurrent code may be billed per patient encounter (regardless of length of concurrent infusion)
- Drugs must be in separate bags



Additional Sequential Infusion

- Use to report a sequential infusion of an additional substance or drug
- Use “each additional hour” codes to report additional hours of sequential infusions



5. Length of Administration

- Identify the length of each infusion to determine code(s) & billing units:
 - IV infusions lasting less than or = 15 minutes will be billed as an IV push



Infusion Time

- Infusion time reflects the time the drug/substance is actually being administered.
 - Do not include drug preparation time as infusion time.
- Document start and stop times for each drug
- Rounding - After the first hour of infusion, round additional infusion times to the nearest 30 minutes:
 - 90 minute infusion = round to 1 hour
 - 91 minute infusion = round to 2 hours



Each Additional Hour Codes

- Use to report additional hours of infusion, after the first hour, of an individual substance or drug.
- To bill the infusion code for “each additional hour” the infusion time must be greater than 30 minutes beyond the end of the previously billed hour.

Example: the patient receives an infusion of a single drug that lasts 1 hour and 45 minutes, the provider would bill for the first hour with either the “initial” or “subsequent” drug administration code, and would bill 1 unit of the add-on “each additional hour” code for the additional 45 minutes.



BILLING UPDATES & REMINDERS



Hydration, Therapeutic/Diagnostic Injections & Infusions

- 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



Chemotherapy

- 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
 - Preparation of chemotherapy agent(s)



Drug Administration OPPS

- OPPS provides a separate APC payment for each reported unit of a separately payable CPT
- CPT codes and billing rules for drug administration are the same as those used in the physician office with a few exceptions:
 - 96368 concurrent infusion is not payable in the HOPD
this is a packaged service
 - Hierarchy used to determine “initial” service



Documenting Drug Administration

- Documentation for drug administration services:
 - Type of administration
 - Start/stop time for each fluid/drug
 - Concurrent or sequential,
- Office visit on same day as drug administration
 - Office visit must be billed with modifier -25
Significant separately identifiable service



Therapeutic/Diagnostic Injections

- Report code 96372 for therapeutic/diagnostic subcutaneous or intramuscular injections
- 96372 may be reported for each injection of a different drug administered during a patient encounter
- Use the -59 modifier when reporting 96372 on the same day as drug administration services
 - The National Correct Coding Initiative (NCCI) created edits on code 96372 which requires the use of a modifier. If the drug or substance is unrelated to an anesthetic, providers should use the -59 modifier to bypass the edit.



Modifier 59

“Modifier 59 is used appropriately for two services described by timed codes provided during the same encounter only when they are performed sequentially.

There is an appropriate use for modifier 59 that is applicable only to codes for which the unit of service is a measure of time (e.g., per 15 minutes, per hour). If two timed services are provided in time periods that are separate and distinct and not interspersed with each other (i.e., one service is completed before the subsequent service begins), modifier 59 may be used to identify the services.”



Medicare - New Subset of Modifier -59

CMS has developed the following new HCPCS as a subset of Modifier 59:

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

Modifier -59 is still valid and will be recognized by Medicare, however it should not be used when a more descriptive modifier is available.

CMS states that MACs are not prohibited from requiring the use of the selective modifiers in lieu of the general -59 modifier.



New Code in 2017 - 96377

Code 96377 has been added to the CPT® 2017 code set in the Medicine/Therapeutic, Prophylactic, and Diagnostic Injections and Infusions subsection of the CPT code set.

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

96377 describes the work of preparing and applying the on-body injector to administer the drug subcutaneously.

96377 is not payable by Medicare – use 96372 to report the administration of Neulasta Onpro® to Medicare

Some commercial payers are paying on this code.



Prolonged Drug & Biological Infusions – External Ambulatory Infusion Pump – Private Payers

- CPT 96416 *Chemotherapy administration, intravenous infusion technique; initiation of prolonged chemotherapy infusion (more than 8 hours), requiring use of a portable or implantable pump*
- CPT 96421 *Refilling and maintenance of portable pump*



Prolonged Drug & Biological Infusions – External Ambulatory Infusion Pump - Medicare

- CMS established a new code **G0498** for billing the services and ambulatory infusion pumps used in extended IV infusions that are started in the clinic and continue in the patient's home.
- **G0498** Long Descriptor: *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.*



Central Venous Access Procedures

CODE	Description
36591	Collection of blood specimen from a completely implantable venous access device
36592	Collection of blood specimen using established central or peripheral catheter, venous, not otherwise specified (use this code for PICC line or peripheral IV)
Rules: Medicare – Only paid if there are no other services payable under the physician fee schedule billed on the same date by the same provider AMA CPT Guidelines – Do not report with any other service except a laboratory service	
36593	Declotting by thrombolytic agent of implanted vascular access device or catheter
36415	Collection of venous blood by venipuncture
Rules: Medicare – Separately payable AMA CPT Guidelines – Separately payable	






Evaluation & Management (E/M) Visits

- E/M visits (e.g., 99201-99205, 99212-99215) performed on the same day as drug administration services are separately reportable with modifier 25 if the practitioner provides a “significant and separately identifiable” E/M service.
- Under OPPS, hospitals may report drug administration services and facility-based E/M codes (e.g., 99212-99215) if the E/M service is significantly and separately identifiable.
- CPT 99211 is not separately reportable with drug administration services.



NCCI Website

www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/

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[Update Changes](#)

[PTP Coding Edits](#)

[Add-on Code Edits](#)

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National Correct Coding Initiative Edits

Important notice to all NCCI Users concerning the *National Correct Coding Initiative Policy Manual for Medicare Services*:

The annual updated version of the *National Correct Coding Initiative Policy Manual for Medicare Services* is effective January 1, 2017. Additions/revisions to the manual have been italicized in red font.

National Correct Coding Initiative

The CMS developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control improper coding leading to inappropriate payment in Part B claims. The CMS developed its coding policies based on coding conventions defined in the American Medical Association's CPT Manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices. The CMS annually updates the **National Correct Coding Initiative Coding Policy Manual for Medicare Services** (Coding Policy Manual). The Coding Policy Manual should be utilized by carriers and FIs as a general reference tool that explains the rationale for NCCI edits.



NCCI Website

www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/

Downloads

[How to Use The National Correct Coding Initiative \(NCCI\) Tools \[PDF, 1MB\]](#) 

[R1386CP \[PDF, 167KB\]](#) 

[MM5824 \[PDF, 69KB\]](#) 

[NCCI Policy Manual for Medicare Services - Effective January 1, 2014 \[ZIP, 749KB\]](#) 

[NCCI Policy Manual for Medicare Services - Effective January 1, 2015 \[ZIP, 1MB\]](#) 

[NCCI Policy Manual for Medicare Services - Effective January 1, 2016 \[ZIP, 761KB\]](#) 

[NCCI Policy Manual for Medicare Services - Effective January 1, 2017 \[ZIP, 770KB\]](#) 



[Correspondence Language Manual for Medicare Services – Effective April 1, 2016 \[PDF, 195KB\]](#) 

[Correspondence Language Manual for Medicare Services – Effective April 1, 2017 \[PDF, 187KB\]](#) 

[Chapter 23 - Fee Schedule Administration and Coding Requirements \[PDF, 1MB\]](#) 

[Modifier 59 Article: Proper Usage Regarding Distinct Procedural Service – Updated 11/16/16 \[PDF, 106KB\]](#) 



Related Links

[NCCI Edit FAQs](#)



RESOURCES

Medicare Claims Processing Manual, Chapter 17 Drugs and Biologicals

<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c17.pdf>

CMS - JW Modifier: Drug/Biological Amount Discarded/Not Administered To Any Patient Frequently Asked Questions

www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Downloads/JW-Modifier-FAQs.pdf



THANK YOU!

