POHMS 2012 Annual Conference

UNDER THE BIG TOP!

Billing and Coding Oncology Services

Back to the basics….

Disclaimer

The information provided in this presentation is for informational purposes only. Information is provided for reference only and is not intended to provide billing, coding, reimbursement or legal advice.

Laws, regulations, and policies concerning reimbursement are complex and are updated frequently and should be verified by the user. Please consult your legal counsel or reimbursement specialist for any reimbursement or billing questions.

You are responsible for ensuring that you appropriately and correctly bill and code for any services for which you seek payment. We do not guarantee the timeliness or appropriateness of the information contained herein for your particular use.

“Don’t believe anything I tell you!”

Use the references – interpret for yourself!

AMA CPT®

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Medicare

Greatest source of revenue is not fee for service

- Buy drugs first, then try to get the $$ back
- This specialty is always changing
  - New drugs
  - New indications for existing drugs
  - New protocols
  - Supportive care drugs
  - Chemotherapy enhancers
  - Quality Initiatives
- Complicates reimbursement at the biller level
- Complicates reimbursement at the payer level

Why Should I Learn This Stuff?

- If you have anything to do with providing services which are billed to a payer, documentation, coding, or billing, you have a responsibility to understand the rules….

Office of Inspector General on Fraud…..

* * * * *

Should know or *should have known* means that a person, with respect to information—

(1) Acts in deliberate ignorance of the truth or falsity of the information; or

(2) Acts in reckless disregard of the truth or falsity of the information. For purposes of this definition, no proof of specific intent to defraud is required.

* * * * *

Fraud Seems to Be On the Rise…

U.S. Department of Health & Human Services www.hhs.gov

Medicare Fraud Strike Force Charges 91 Individuals for Approximately $430 Million in False Billing

October 4, 2012

SHARE

Medicare Fraud Strike Force operations in seven cities have led to charges against 91 individuals – including doctors, nurses and other licensed medical professionals – for their alleged participation in Medicare fraud schemes involving approximately $429.2 million in false billing, Attorney General Eric Holder and Health and Human Services (HHS) Secretary Kathleen Sebelius announced today. Read the Press Release >>

Oncologist and Biller….GUILTY!

Summit Oncologist, Madison Biller Plead Guilty to Health Care Fraud

U.S. Attorney's Office
July 13, 2012

Southern District of Mississippi
(601) 965-4480

JACKSON, MS—Dr. Meera Sachdeva, 50, of Summit, Mississippi, and Monica Weeks, 40, of Madison, Mississippi, each pled guilty today to charges of Medicare fraud, U.S. Attorney Gregory K. Davis, FBI Special Agent in Charge Daniel McMullen, and Mississippi Attorney General Jim Hood announced.

Sachdeva, who owned and operated Rose Cancer Center in Summit, pled guilty to submitting claims for chemotherapy services that were supposedly rendered when she was out of the country. Weeks, who owned and operated The Medical Billing Group in Madison, pled guilty to conspiracy to commit health care fraud by covering up false claims made by Sachdeva that were scheduled for an audit.

Huge Amounts of Fraud….

Las Vegas doctor to pay nearly $500,000 over Medicare fraud allegations

STEVE MARCUS

Dr. Navneet Sharda displays paperwork and legal documents in March 2009. He won a $60,000 verdict against a fellow doctor. Sharda says defamed him by criticizing his character and medical expertise.

By Jackie Valley (contact)
Monday, Sept. 24, 2012 | 6:15 p.m.

Oncology again….

Local Oncologist Guilty of Medicare Fraud Will Keep License

Dr. Glen Justice will instead be placed on 10 years probation upon his release from prison.

By Justin Petruccelli | Email the author | March 22, 2012

Recommend 1 Tweet 0 Email Print 2 Comments

Dr. Glen Justice, the Fountain Valley oncologist convicted last year on five counts of Medicare fraud, will not lose his medical license once he's released from prison, according to documents released last week by the California State Medical Board.

Justice, 66, was sentenced in July of last year to 18 months in prison after pleading guilty in March 15 of 2010 of bilking Medicare and private insurance providers out of more than $1 million for medications that were never administered. He was the head of Orange Coast Memorial Medical Center's cancer center and also owned Pacific Coast Hematology/Oncology Group in Fountain Valley, where the fraudulent Medicare claims

PHOTOS (1)

And so on….

RADIATION ONCOLOGY PRACTICE AND OTHERS SETTLE MEDICARE FRAUD BILLING CHARGES

Written by World Watch | Print | Email

The US Department of Justice (DoJ) has announced that Radiotherapy Clinics and its associated practices RCOG Cancer Centres, Physician Oncology Services Management Company, Dr Frank Critz and Physician Oncology Services (collectively RCOG) have agreed to pay US$3.8 million to settle allegations that they charged Medicare "for medical treatment that they provided to prostate cancer patients in excess of those permitted by Medicare rules and for services that were not medically necessary". It was also alleged that the clinic overbilled Medicare for physics consultations and for pre-plans ordered by Dr Critz that were not medically necessary and/or never reviewed by him.

DoJ's media release (3 April 2012)
(Source: DoJ)

Dr. Glen R. Justice, seen here working in Haiti. He is now serving time for Medicare fraud.

Justice, 67, is serving an 18-month sentence in Lompoc after pleading guilty to five counts of fraud for billing for expensive cancer drugs that were never given to patients. He originally reached a plea deal that called for probation, but federal prosecutors asked for prison time after discovering that Justice continued to submit fraudulent bills after signing the agreement.

Justice's projected release date is April 2013. Afterward, he will be placed on 10 years of medical board probation, which bars him from solo practice and requires him to take an ethics course.

Over the past few years, several Orange County doctors who were convicted of insurance fraud have faced the harshest punishment – loss of their medical licenses.

WA Oncologist Indicted in $1.7M Medicare Fraud Scheme

Alfred Hongleung Chan, 63, and Judy Yuan Chan, 62, face up to 20 years in prison if convicted of the charges, which include obstruction of justice and money laundering. The indictments were handed up earlier this year by a federal grand jury, and unsealed this week in U.S. District Court in Tacoma. Arraignment is scheduled for July 29.

The charges stem from a whistleblower False Claims Act suit by a former employee at the Chans' Lakewood clinic. The indictment and the civil suit allege that, beginning in 2006, Alfred Chan would make patient treatment notes on individual slips of paper which were given to his nurse. The notes specified the amount of drugs to be provided to a specific patient. After the nurse had provided the drugs to patients, the slips of paper were returned to Chan who shredded them. The doctor then made entries into a "Superbill" form, ostensibly recording the amount of medications the patients had received, DOJ said in a media release.

And PAGES more….

New Jersey Psychiatrist Defrauds Medicare and Medicaid for $50,000

Dr. Arnold Jacques was ordered to pay $50,000 in restitution for submitting false claims to Medicare and Medicaid. Between Janurary 2004 and November 2005, Jacques overbilled Medicare for longer therapy sessions than were provided, and for sessions that never took place. While he never rendered the services, Jacques allowed his counterpart to bill Medicare using his provider number. In November 2010, Jacques was sentenced to 3 years in prison.[19]

Michigan Physician Over Charges Medicare for High-End Services

In December 2010, Alan Silber, a Michigan physician, was sentenced to three years in prison for conspiring with others to submit nearly $1 million in fraudulent claims to Medicare. He billed Medicare for injection services, infusion therapy services, and expensive medications between November 2006 and March 2007. Most of the time, these services were unnecessary or un-rendered. Evidence shows that several of his patients were recruited

Two Miami Doctors Convicted of Medicare and Medicaid Fraud

Walter Proano and Manuel Barbeite, both of Miami's Diagnostic Medical Choice, billed Medicare and Medicaid for expensive infusions used to treat a small portion of HIV/AIDS patients. The doctors requested large amounts of prescription drugs but rarely had any in inventory and rarely offered the drugs to patients. The health clinic scammed Medicare out of $15 million from January 2003 through July 2006.[39]

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THE FBI FEDERAL BUREAU OF INVESTIGATION

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Atlanta Division

Leading Oncology Practice to Pay $4.1 Million to Settle False Claims Act Investigation

Georgia Cancer Specialists Overbilled Medicare for Evaluation and Management Services

U.S. Attorney's Office
September 19, 2012

Northern District of Georgia
(404) 581-6000

ATLANTA—The United States Attorney's Office for the Northern District of Georgia announced today that it has reached a settlement with Georgia Cancer Specialists I PC, which agreed to pay $4.1 million to settle claims that it violated the False Claims Act by billing Medicare for evaluation and management services that were not permitted by Medicare rules. Georgia Cancer Specialists is one of the largest private oncology practices in the country with 27 offices located throughout the Atlanta metro area.

Sally Quillian Yates, United States Attorney for the Northern District of Georgia, said, "Health care providers should be on notice that if they inflate their billings, we will aggressively seek to recover not only the overcharges but also significant penalties under the False Claims Act."

Ricky Maxwell, Acting Special Agent in Charge, FBI Atlanta Field Office, stated, "The FBI continues to do its part in ensuring that federal funds appropriated to Medicare are spent appropriately and today's settlement is an example of those efforts. The FBI urges anyone with information related to overbilling or fraudulent billing of our Medicare programs to contact their nearest FBI field office."

"Today's settlement sends a clear message to health care providers across the country that they will be held ponsible if they misrepresent the services they bill to Medicare," said Derrick L. Jackson, Special Agent harge of the U.S. Department of Health and Human Services, Office of Inspector General for the

ters

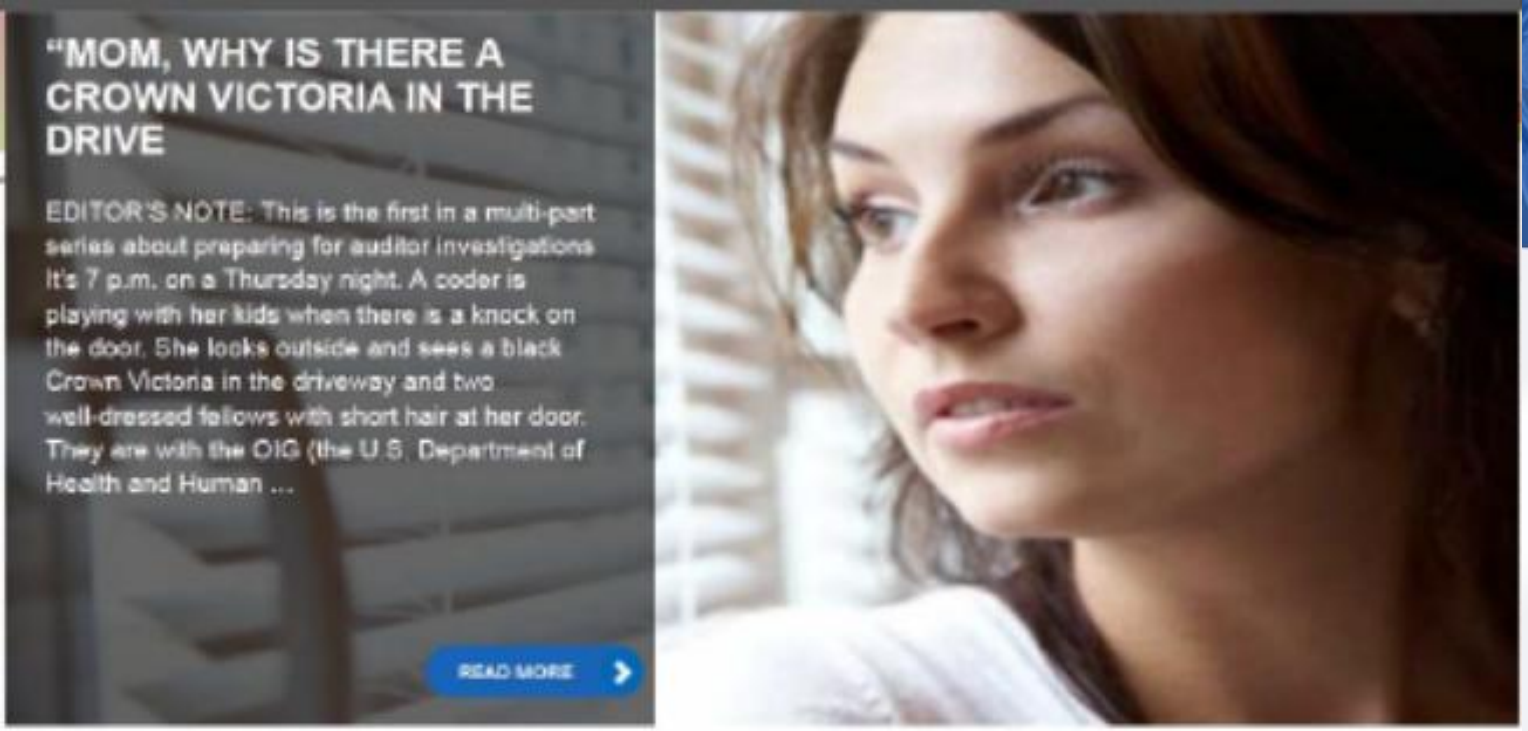
Recent Announcement from the California Oncology Society…

Important message recently sent by the California Oncology Society, MOASC, to their membership regarding importation of drugs....

*****IMPORTANT NOTICE! PAY ATTENTION!*****

THERE ARE MORE THAN 60 MEDICAL ONCOLOGISTS IN CALIFORNIA UNDER CRIMINAL INVESTIGATION BY THE FDA FOR IMPORTATION OF UNAPPROVED DRUG.

In February 2012, many of you heard that a counterfeit supply of Avastin had reached the marketplace. In the March 19, 2012 edition of the *California Oncology Weekly* you were notified of the dangers of suppliers operating on the fringes of the prescription drug market, offering drugs at much lower prices to doctors. You were notified to protect yourself from such fraudulent scams and must conduct due diligence when approached individuals outside the mainstream. Since 2003, MOASC has sent information to its membership regarding importation of FDA unapproved drug. MOASC has ALWAYS instructed members to ensure that the third party they are dealing with is a **federally licensed pharmacy and/or distributor (licensure is dependant upon the FDA and USP criteria)**, and the drugs sold are registered for distribution in the U.S. In general, drugs or devices will be deemed "misbranded" if they are manufactured, prepared, propagated, compounded or processed in a location **not duly registered with the FDA**. (21 USCA 352(o)). Some clues as to the drug being unapproved FDA drug, are: 1) No manufacturer name on package; 2) No NDC number on package; 3) No Package Insert (PI); 4) Package literature written in a language OTHER THAN English. The FDA further explains on its website, that drugs from outside the country are often not approved by the FDA for distribution in the U.S., even though the active components may be identical, because the foreign-made drugs are not formally approved by the FDA, it is illegal to import them.



EDITOR'S NOTE: This is the first in a multi-part series about preparing for auditor investigations

It's 7 p.m. on a Thursday night. A coder is playing with her kids when there is a knock on the door. She looks outside and sees a black Crown Victoria in the driveway and two well-dressed fellows with short hair at her door. They are with the OIG (the U.S. Department of Health and Human Service's Office of Inspector General, the investigative arm for Medicare) and want to ask a few questions about her job.

If you think this can't happen to you, you're wrong. Odds are that more than one recipient of this e-newsletter will experience such a visit during the next year. Because investigations are so common, you should make sure all of your colleagues are prepared so they know how to react. This is the first piece in a series of articles addressing preparation for audits and investigations.

Read more –
www.racmonitor.com

Cause and Effect…..

- How do they combat fraud?
  - AUDIT AUDIT AUDIT
  - Pre-auths, pre-payment reviews, post-payment reviews, physician office infusion audits…
  - The number of auditing bodies is increasing, the number of records being reviewed is rising and the “look back” time periods have expanded from three to five or even seven to ten.

Medicare Auditor Jobs | Simply Hired
www.simplyhired.com/a/**jobs**/list/q-**medicare+auditor**
Jobs 1 - 10 of 71792 – Every **Medicare Auditor job** on the web. 71792 jobs available.
Recent Jobs: Medicare Compliance Auditor, Senior Auditor, Claims Auditor ...

The Rules…..

- Foundation
  - AMA CPT sets the foundation for the rules for billing infusion services
    - You must follow the rules
    - But everything in CPT isn't necessarily paid
  - Medicare policies take the lead in determining whether a service will be reimbursed
    - NCD
    - LCD
    - CCI – Bundled w/other services

The Rules….

- All must follow AMA CPT Code Set
  - Managed Medicare – Beneficiary MUST have same benefit as traditional Medicare
  - Private Payers…Can determine what they will and won't pay for based on their own policies or policy interpretation
    - Watch policies closely
    - If you don't know… ASK! And document the response!

Oncology Reimbursement 101

- 4 Primary Components to oncology billing:
  - Evaluation & Management Codes
    - office visits, hospital visits, etc.
  - Drugs
    - Antineoplastic/Supportive Care
  - Administration
    - Hydration, Therapeutic, Chemotherapy
  - Diagnostic
    - Lab & Bone Marrow

Drug Reimbursement

- Drugs reimbursed by *diagnosis*…
  - ICD-9-CM (International Classification of Disease, 9th Revision)
    - Staging is not included in ICD-9
    - ICD-10 coming in 2014???
- FDA Approved Indications
  - Reimbursed *if medically necessary*
- Off Label
  - Generally reimbursed if use is “medically accepted standards of medical practice”
  - Most use/accept NCCN Guidelines
  - CMS list of approved journals

Drug Reimbursement

- Medicare establishes…
  - NCD – National Coverage Determination
    - Not many individual drugs listed
      - Provenge NCD
        - » 2 dx codes/administration (finally)
        - » Q-Code – unique to private practice
  - LCD – Local Carrier Determination
    - Majority of reimbursement determinations made through local CAC process
      - LCD for J11 – Chemotherapy Drugs Retired……
      - Billing for “off label” indications

Drug Reimbursement-Terms

- WAC = Wholesale Acquisition Cost
  - The list price for wholesalers, distributors, and other direct accounts before any rebates, discounts, allowances, or other price concessions that might be offered by the supplier of the product
  - Used primarily by Medicare/Medicaid for new drugs until a full quarter of ASP data has been collected

- AWP = Average Wholesale Price
  - A national average of list prices charged by wholesalers to purchasers; AWP is sometimes referred to as “sticker price” because it is not the actual price that larger purchasers normally pay
  - Still used occasionally by private payers (AWP = −5% to −15%)

Drug Reimbursement-Terms

- ASP = Average Sales Price
  - The Medicare Modernization Act (MMA) defines ASP as a manufacturer's sales of a drug to all nonexempt purchasers, which are those entities that do not receive "best price," such as 340B hospitals, in the United States in a calendar quarter divided by the total number of units of the drug sold by the manufacturer in that same quarter
    - The ASP is the net of any price concessions such as volume, prompt pay, and cash discounts; free goods contingent on purchase requirements; chargebacks; and rebates other than those paid under the Medicaid drug rebate program
  - Used primarily by Medicare and some private payers
    - Many private payers create their own version of ASP

Drug Reimbursement-Terms

- AMP – Average Manufacturer Price
  - Average price paid to the manufacturer by wholesalers
- WAMP – Widely Available Market Price
  - OIG definition: The price that a prudent physician or supplier would pay for the drug including rebates, discounts and other price concessions routinely made available

CMS Drug Reimbursement Substitution

- Currently - If OIG finds that the ASP of a drug exceeds either the WAMP or AMP by a certain threshold (currently 5 percent), CMS may disregard the ASP for the drug when setting reimbursement amounts and substitute the lesser of WAMP or Average Manufacturer Price +3%
  - 1/9/2012 excerpt from OIG report:
    - *Limitations and irregularities in the sales data provided by the distributors and manufacturers called into question the data's accuracy and reliability, and prevented us from measuring WAMPs against the threshold*
      - https://oig.hhs.gov/oei/reports/oei-03-10-00280.pdf

Drug Reimbursement

- Reimbursement
  - New Drug
    - WAC +6% or invoice pricing
  - Private Practice (CMS 1500 Form)
    - New Drug – WAC +6% or invoice pricing
    - Established ASP – ASP +6%
  - Outpatient Hospital – HOPPS (UB04 Form)
    - New Drug – 95% of AWP
    - Packaged - <$75.00 not paid separately (APC Pmt)
    - Pass Through – Drug usually older than 2 years – ASP +5% (up from ASP+4% last year)
    - Non Pass Through – new drugs usually less than 2 years old – ASP +6%

Drug Reimbursement

- Quarterly ASP reporting
  - 6 month lag in price changes
    - One qtr report, one qtr analyze, one qtr release new price
- Manufacturers are required to use the formula established by CMS
- Manufacturers' discounting/fee structures and strategies vary
  - Results in some variation across industry
  - OIG reported MANY mistakes by manufacturers
    - Comparison of Average Sales Prices to Widely Available Market Prices for Selected Drugs

340 B Pricing

- Established under the Veterans Health Act of 1992, 340B allows specific government supported facilities access to limited cost of outpatient drugs
  - Discounts estimated by to 20% - 50% and apply to both indigent and fully insured patients
  - 2010 statutory price discount raised from 15.2% to **23.1**% and the program was expanded to allow additional types of hospitals
    - FAQ's for 340B - http://www.hrsa.gov/opa/faqs/index.htm

340B Pricing

- To Participate in 340B the hospital must…
  - Have government ownership
    - City, county or state ownership or
    - Private non-profit with government contract to provide healthcare services to low income individuals who are not entitled to benefits under Medicare or Medicaid
  - Sign a written certification of non-participation in Group Purchasing Organizations for covered outpatient drugs
  - Possess the necessary level of Medicare disproportionate share
    - Criteria based inpatient services provided to Medicaid and Medicare patients

Growth and awareness of 340B pricing is a large reason why so many practices have been purchased by hospitals

Drugs -

- HCPCS Drug Codes for private practice….
  - ASP Drug Pricing File released quarterly by CMS
    - http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/2012ASPFiles.html
- HCPCS Drug Codes for Outpatient Hospital…..
  - Addendum B – updated quarterly by CMS
    - http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html

Drugs -

- Outpatient Hospital Tip…..
  - On the addendum B - next to the drug you will also see a Status Indicator. Status indicators show if the drug is Pass-through (G) or Non-pass-through (K) or is Packaged (N)
    Here is a link to the status indicator listing - Addendum D1:
    http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Downloads/CMS1392FC_Addendum_D1.pdf

Addendum B.-Final OPPS Payment by HCPCS Code

CPT codes and descriptions only are copyright 2011 American Medical Association. All Rights Reserved. Applicable FARS/DFARS Apply. Dental codes (D codes) are copyright 2011/12 American Dental Association. All Rights Reserved.

HCPCS Code	Short Descriptor	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment	* Indicates a Change
J9250	Methotrexate sodium inj	N						
J9260	Methotrexate sodium inj	N						
J9261	Nelarabine injection	K	0825		$120.33	.	$24.07	*
J9263	Oxaliplatin	K	1738		$9.07	.	$1.81	*
J9264	Paclitaxel protein bound	K	1712		$9.41	.	$1.88	*
J9265	Paclitaxel injection	N						
J9266	Pegaspargase injection	K	0843		$5,778.86	.	$1,155.77	
J9268	Pentostatin injection	K	0844		$929.05	.	$185.81	*
J9270	Plicamycin (mithramycin) inj	N						
J9280	Mitomycin 5 MG inj	K	1232		$22.47	.	$4.49	*
J9293	Mitoxantrone hydrochl / 5 MG	K	0864		$35.53	.	$7.11	*
J9300	Gemtuzumab ozogamicin inj	K	9004		$2,690.84	.	$538.17	
J9302	Ofatumumab injection	G	9260		$45.44	.	$8.92	*
J9303	Panitumumab injection	K	9235		$87.34	.	$17.47	*
J9305	Pemetrexed injection	K	9213		$55.44	.	$11.09	*
J9307	Pralatrexate injection	G	9250		$173.04		$34.13	*

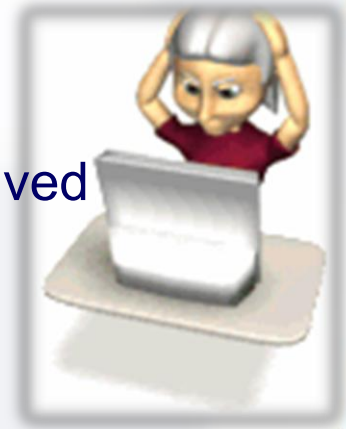
2012 October Addendum B

Drugs -

- **Healthcare Common Procedure Coding System (HCPCS) Level II Codes**
  - HCPCS codes - "J-codes"
    - 5-digit alphanumeric codes assigned to drugs by CMS.
    - Updated quarterly on the www.cms.gov website
    - J code: used to bill private and public payers for drugs
    - J Codes and some C codes: used to bill Medicare for drugs administered in the Hospital Outpatient Department (HOPD)
  - When billing for a drug, indicate the quantity of product administered to the patient ***expressed in the number of units described by the HCPCS code***
    - ***Example – Avastin****/bevacizumab* =
    - *J9035* (Injection, *bevacizumab*, 10 mg
    - ***200 mg of Avastin is billed as 20 Units***

Drugs -

- HCPCS do not always equal Vials
- HCPCS do not always equal ONE
  - Mg, mcg, unit, gm, ml, cc, IU, dose
- HCPCS do not always equal the amount the patient received
  - **Roll up** to the nearest billable unit
    - 222 mg of Avastin – bill as 30 units
- HCPCS do not always equal the total amount used
  - Document waste and bill for the entire single dose vial
    - Novitas Solutions does not require the use of the JW modifier



- Medicare Claims Processing Manual, Chapter 17 – Drugs and Biologicals
  - http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c17.pdf
  - Rules for both outpatient hospital and private practice

Drugs -

- Physician Order
  - Must have a signed physician order
  - Order must contain “Magic Six”
    - Drug, dose, route of administration, frequency, duration and signature
  - Services rendered must match the physician order
    - More on this topic in the Audits portion of the program today including verbal orders, amending orders..etc.

Drugs - Billers to Nurses…

- **WATCH OUT……..**
  - **Only** bill for waste from a Single Dose Vial
    - Waste from a multi dose vial cannot be billed
  - When billing for waste, the waste **must** clearly be documented
    - IN THE PATIENT's MEDICAL RECORD

  - **Never** bill for overfill in a vial
    - CMS Final Rule – 2011 prohibits billing of "intentional overfill"
      - CMS sets payments based on the FDA vial or container reflected on the FDA-approved label
      - Cannot bill CMS for anything received for free

Administration Coding

- Three Primary Categories

1. Hydration
    - Pre-packaged fluids and electrolytes
2. Therapeutic or Diagnostic
    - Pre-meds, anti-emetics, anti-anemia drugs fall in this category
3. Chemotherapy
    - Injections, pushes and infusions

Administration Coding

- Hierarchy
  - Chemo Infusion/Injection – primary to…
    - Therapeutic Infusion/Injection primary to…
      - Hydration

  - Infusions – primary to…
    - Pushes – primary to…
      - Injections

One “Initial” Administration Code Allowed Per Day

- Medicare says they will allow only 1 "initial" infusion code per patient per day:

  “If a combination of chemotherapy, nonchemotherapy drugs, and/or hydration is administered by infusion sequentially, the initial code that best describes the service should always be billed irrespective of the order in which the infusions occur.“

- Exception:
  - If there are two separate IV’s running (two IV starts), a patient must return to the practice to receive another course of therapy in the same day
    - must be medically necessary

- DO NOT report second initial service for re-starting an IV, an IV rate not being able to be reached without two lines, or for accessing a port of a multi-lumen catheter” **AMA CPT 2013

Administration Coding

- Push
  - A push is always billed as a push regardless of the amount of time spent
    - Not a time based code
    - YOU MUST DOCUMENT THE PUSH TIME!

- Infusions - Only 2 time related rules
  1. Infusions of 15 min. or less must be billed as a push
  2. To bill for a 2nd hour, (each additional hour code), you must exceed 30 minutes
     - 90 minute infusion is billed as 1 hour

Administration Coding

- Each group has at least one initial service code:
  - Initial Hydration 96360
    - 31 min up to 90 min
  - Initial Therapeutic Infusion - 96365
    - 16 min up to 90 min
  - Initial Therapeutic Push - 96374
  - Initial Chemotherapy Infusion - 96413
    - 16 min up to 90 min
  - Initial Chemotherapy Push – 96409

Why is the patient being seen?
Determine the “initial code” based on that!
Then use hierarchy…

Administration Coding

- Initial codes are paid at a much higher rate because the following is included in administration code payment….
  - Use of local anesthesia;
  - IV start;
  - Access to indwelling IV, subcutaneous catheter or port;
  - Flush at conclusion of infusion; and
  - Standard tubing, syringes and supplies.

  – IMPORTANT REMINDER…
    - Physician work related to hydration, injection and infusion services involves the affirmation of the treatment plan and the direct supervision (pursuant to “incident to” requirements) of non-physician clinical staff

Administration - Hydration

- Hydration
  - Hydration is defined as the replacement of necessary fluids via an IV infusion which consists of pre-packaged fluids and electrolytes
  - Reporting Hydration services
    - 96360 (initial 31 minutes to 1 hour)
    - 96361 (each additional hour)*must exceed 30 minutes bill additional hour
      - CPT Note: use 96361 to identify hydration if provided after a different initial service
        - » CPT then lists all initial codes in the therapeutic and chemo section
  - IV fluids reported for hydration lasting 30 minutes or less is not reported using infusion codes
  - Hydration services must be **medically necessary**
  - DO NOT fill for hydration concurrent with any drug administration
  - DO NOT bill Hydration when keeping a line open
  - DO NOT bill for hydration unless it is medically necessary the patient receives the fluid!

Administration - Hydration

- Examples of hydration services that may be medically necessary
  - Pre and post hydration services with chemotherapy (orders and notes must clearly document medical necessity of “pre-hydration/post-hydration”)
  - Normally prepackaged IV fluids (such as D5 1/2NS with 20 mEq KCL) run at a rate targeted to treat dehydration or volume depletion in patients with GI disturbances or poor nutrition
- Services that would not be considered medically necessary hydration
  - Keep Open or KVO solutions
  - Flush solutions before and after a medication
  - Diluent fluids for other medications
  - Fluids used to run IV piggyback drugs or other infusions
- Factors to consider when choosing appropriate CPT code selection
  - Reason for encounter
  - Other infusion/injection services provided at same encounter
  - Medical necessity of fluid administration
  - Length of infusion time
  - Type of infusion and treatment provided

Administration Coding

- Additional infusions/injection of a new substance will be coded with sequential (or concurrent) codes:
  - sequential chemotherapy infusion - 96417
    - 16 min up to 90 min
  - sequential chemotherapy push - 96411
  - sequential therapeutic infusion – 96367
    - 16 min up to 90 min
  - sequential therapeutic push – 96375
  - concurrent therapeutic infusion - 96368

Administration Coding

- Facility Setting ONLY

- 96376 – add'l sequential IV push of the same substance/drug provided by a facility
  - Do not report for a push performed within 30 minutes of a reported push of the same substance/drug

Administration Coding

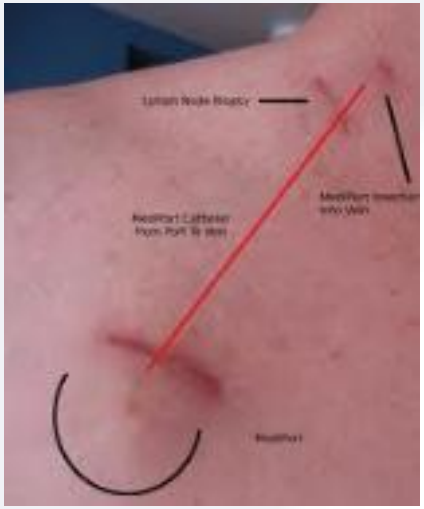
- **Add-on** codes for infusions that run greater than 30 min beyond 1 hour increments:
  - each add'l hour of chemo infusion - 96415
  - each add'l hour of therapeutic infusion 96366
  - each add'l hour of hydration 96361
    - ***96361 is the only "add on" code that can be utilized as a "sequential" code for hydration
  - Added to the first hour…
  - Must be medically necessary
    - Drug ordered for 90 minute infusion – runs over 95 minutes – Do not bill the 2nd hour!

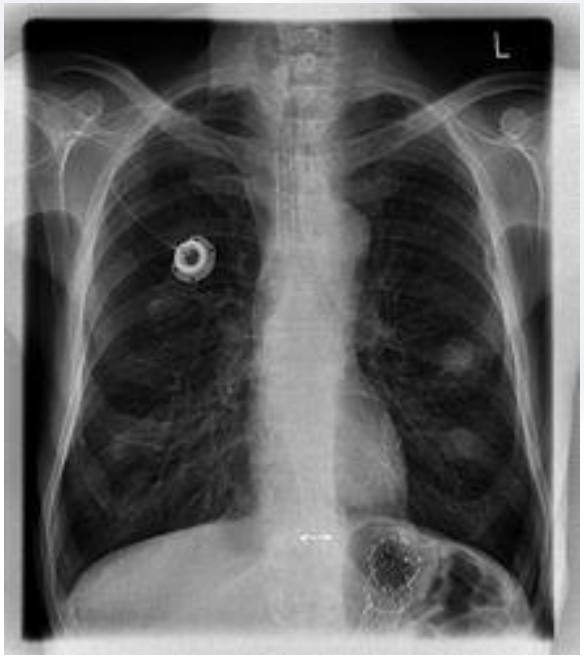
Administration Coding

- Documentation of the start and stop time is essential critical to distinguish if the drug administered is initial, sequential, additional, and current!
  - Time does not start until the drug starts dripping!

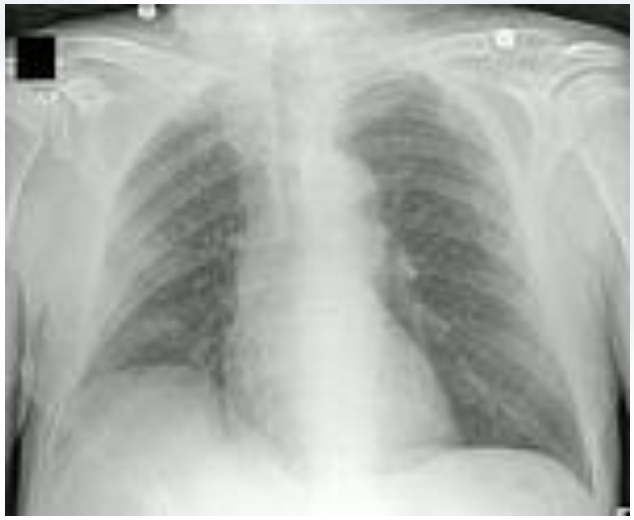
Administration –

- Mediport (port)
  - A port (often referred to by brand names such as *Port-a-Cath* or *MediPort*) is a central venous line that does not have an external connector; instead, it has a small reservoir that is covered with silicone rubber and is ***implanted*** *under the skin*



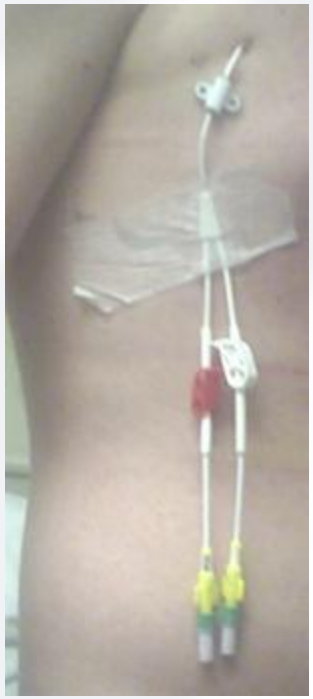


- Picc Line
  - A **peripherally inserted central catheter** (**PICC** or **PIC line**) is a form of intravenous access that can be used for a prolonged period of time



Administration – Nurses Language

- Hickman line/Broviac catheter
  - is inserted into the target vein and then "tunneled" under the skin to emerge a short distance away. This reduces the risk of infection, since bacteria from the skin surface are not able to travel directly into the vein; these catheters are also made of materials that resist infection and clotting.



Administration Coding

- Port flush -96523 Irrigation of **implanted** venous access device
  - "**do not** report 96523 in conjunction with other services"
- So what do you use for a flush of a picc line or Hickman?
  - Many use the unlisted chemotherapy procedure code 96549 with a description of the service
- Declotting by thrombolytic agent of implanted vascular access device or catheter - 36593

Administration Coding

- Pumps
  - 96416 – initiation of prolonged chemotherapy infusion (more than 8 hours) requiring use of a portable or implantable pump
  - 96521 – refilling **AND** maintenance of a portable pump
    - There is not a code for taking off a pump, this code cannot be used

Let's code the Hydration

- Let's Bring Up Our Patient!!!
- SHOUT IT OUT…..
  - Can we bill?
  - Should it be paid?
  - What is the code(s)?
  - What should be documented?
- 96360 – Initial 1st hour
- 96361 – "each additional hr"

Let's Code The Treatment!

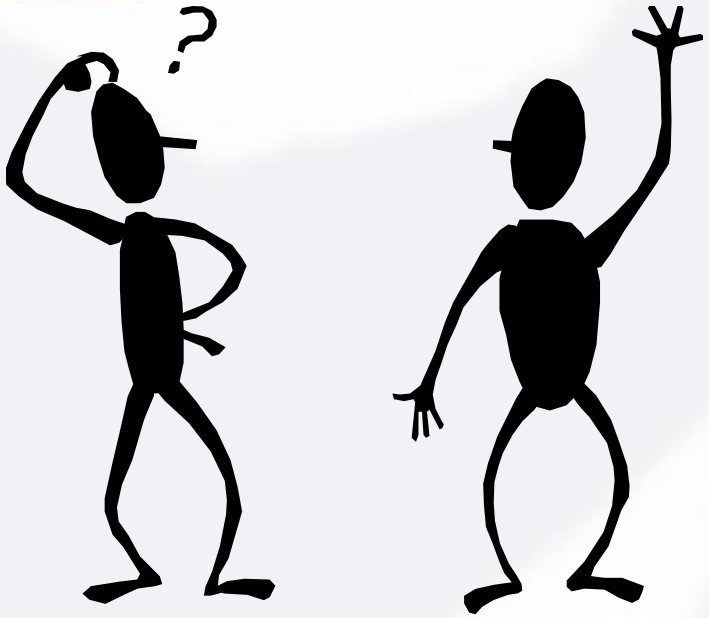
- SHOUT IT OUT…..
  - Can we bill?
  - Should it be paid?
  - What is the code?
  - What should be documented

	Therapeutic		**Chemo**
96365	Initial IV inf. up to 1 hr	96413	Initial IV inf. up to 1 hr
96366	each add'l hr	96415	each add'l hr
96367	sequential IV inf. up to 1 hr	96417	sequential IV inf. up to 1 hr
96368	concurrent infusion	xxx	concurrent infusion
96374	Initial IV Push	96409	Initial IV Push
96375	sequential IV Push	96411	sequential IV Push
96523	Port Flush	96416	Initiation of prolonged chemo
		96523	refilling and maintenance pump
NOTE: FOR EXAMPLE ONLY - LIST NOT ALL INCLUSIVE - REFER TO CPT BOOK EXAMPLE ONLY - These are codes that may be used in our coding scenerio			

Coding Oncology Claims

- GET IT RIGHT
- Don’t let money walk our your door
- Don’t let a payer take money back simply because of bad documentation
- Don’t open yourself up to questionable billing practices
- Be proactive – establish a compliance plan and perform regular self audits
- Keep attending meetings, the healthcare environment is continuously changing!

Questions???



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