

## Updated FAQs on Changes to Payments for Drugs and Drug Administration Services

ASCO has updated the Frequently Asked Questions, which was originally published on January 14, 2004. The questions found in the document relate to the Centers for Medicare & Medicaid Services' (CMS) Interim Final Rule entitled "Changes to Medicare Payment for Drugs and Physician Fee Schedule Payments for Calendar Year 2004." Some answers have been updated to reflect our current understanding of CMS's payment policies. Information that has been updated can be identified by the (\*) symbol. Please note that the answers address Medicare policy only; other third-party payers may or may not be implementing similar policies.

We encourage you to check the ASCO website at [www.asco.org/medicare](http://www.asco.org/medicare) regularly for updates to the following information.

### Billing/Coding

Q1. Can a level 1 visit (99211) be billed on the same day as a drug administration service for a medical concern that is unrelated to the chemotherapy administration? For example, a patient who comes in for drug therapy has some medical questions or symptoms requiring nurse assessment unrelated to the drugs administered and for which the physician is consulted by the nurse but for which the physician does not directly see the patient. Previously, the office could bill a level 1 visit in addition to the drug administration code. Has this changed now that Medicare considers a physician work component to be included in the drug administration codes?

\*A. The Federal Register notice states that Medicare will no longer allow for 99211 to be billed on the same day as a chemotherapy administration service. The reason stated is that the new physician work component in the drug administration codes subsumes the physician supervision that physicians billing a 99211 on the same day are typically providing.

ASCO's understanding of CMS's current payment policy is that a 99211 should not be billed on the same day as chemotherapy administration even when the service is unrelated to the drug administration.

Q2. Now that Medicare will pay for multiple pushes on the same day, how should they be coded on the CMS-1500 form? Is it necessary to append a modifier to CPT code 96408?

\*A. No modifier should be necessary. The CMS-1500 form should include the HCPCS code for each drug administered via push and CPT code 96408 with the corresponding number of units of service. For example:

J9XX1 x 1 unit  
J9XX2 x 1 unit  
96408 x 2 units

Coverage of multiple pushes is discussed in Medicare's Program Transmittal 34, published on December 24, 2003. This transmittal should be provided to your carrier if you are experiencing coverage problems with your local carrier. The link to the transmittal is

[http://www.cms.hhs.gov/manuals/pm\\_trans/R34OTN.pdf](http://www.cms.hhs.gov/manuals/pm_trans/R34OTN.pdf)

- Q3. Is a separate (non-chemotherapy, non-cancer related) diagnosis required to bill a separately identifiable evaluation and management (E&M) service in conjunction with chemotherapy administration?
- A. The CMS regulation does not implement any requirement that a separate diagnosis must be reported to justify billing for a separately identifiable E&M service in conjunction with chemotherapy administration.
- Q4. What sort of documentation is required to justify billing an E&M visit in conjunction with a chemotherapy administration code (do these requirements differ from before)?
- A. The documentation requirements have not changed. Documentation for the E&M service must justify the level of visit being billed, in accordance with either the 1995 or 1997 Medicare documentation guidelines. To be paid under the new rules, you must demonstrate that the E&M service is above and beyond the drug administration service and use the -25 modifier in conjunction with the E&M code.
- Q5. Can 99211 be billed with nonchemotherapy drug infusion codes (90780-90781)?
- \*A. ASCO's understanding of CMS's current payment policy is that a 99211 should not be billed on the same date of service as the nonchemotherapy infusion. If a higher level office visit occurs, the -25 modifier should be used in conjunction with the E&M code. Appropriate documentation in the patient's medical record should support the level of service provided.
- Q6. Can 99211 be billed with nonchemotherapy drug injection codes (90782-90788)?
- A. ASCO's interpretation of the rule is that CMS has not changed its existing policy which does not allow payment for an injection code on the same day as another physician fee schedule service. Therefore, if a 99211 visit is billed, 90782 will not be paid.
- Q7. For port flush payments, physicians are currently only receiving a level 1 visit and the heparin payment. Are they going to face denials for the level 1 or are they now allowed to use other codes?
- A. Section 15400 of the Carriers Manual states that flushing a port prior to administration of chemotherapy is integral to the chemotherapy procedure and is not

separately billable. The Manual further states, however, that if a special visit is made to the office just for port flushing, 99211 may be billed. Finally, the Manual states that 96530 should not be used to report port flushing. We believe that these policies remain in effect.

Q8. Have the rules for billing 96530 changed?

A. No. See previous Q&A.

Q9. Does the -25 modifier need to be used in conjunction with an E&M code in the following scenario? The patient receives chemotherapy administration in a cancer center. The hospital bills for the chemotherapy administration. The physician performs an E&M service (e.g., 99213). Does the physician need to use a -25 modifier when billing just the 99213?

A. No. The need for a modifier arises only if the physician provides both the chemotherapy administration services and an unrelated E&M service on the same day.

\*Q10. Now that there is a work value associated with the drug administration codes, does that change any documentation requirements?

A. ASCO's understanding is that there is no new requirement to document physician work in connection with drug administration and that the documentation in the medical record should continue to be consistent with good medical practice. Documentation should appropriately describe the service performed.

## **Drug Payments**

Q11. What will be the 2004 payment rate for bortezomib (Velcade)?

A. Bortezomib was approved by the FDA in May 2003 and therefore had no associated AWP in April 2003. We expect that the drug will be paid at 95% of AWP. In CMS's Federal Register notice on hospital outpatient department payments, where bortezomib is also paid based on 95% of AWP, the payment amount is \$1,039.68 per 3.5 mg.

Q12. What will the 2004 payment rate be for dexrazoxane HCl (Zinecard)?

A. Dexrazoxane HCl should be billed using J1190 and will be paid at \$209.34.

Q13. Have errors been made in determining the payment rate for fulvestrant (Faslodex)? It seems too low.

A. The HCPCS code for 25 mg of fulvestrant is J9395. The current AWP listed in the Red Book for 5 ml of fulvestrant at 50 mg/ml (or 250 mg) is \$921.29. Therefore,

the AWP for 25 mg would be \$92.13 and 85% of that would yield a payment rate of \$78.31. CMS has posted a rate of \$78.36 for J9395.

Q14. To what units does the new HCPCS code J9263 for oxaliplatin (Eloxatin) apply?

A. J9263 codes for 0.5 mg of oxaliplatin.

Q15. Some billing software will not accept the 3 digit unit that will be required to bill for oxaliplatin (the new HCPCS code for oxaliplatin is for only 0.5 mg – to bill for 150 mg, 300 units will need to be billed). How should this drug be billed?

A. The manufacturer of Eloxatin has indicated that HIPAA-compliant electronic transactions should be able to accommodate 3 digit billing fields. You should not experience problems billing Medicare. Following are the manufacturer's instructions for non-HIPAA compliant transactions using the example above of 300 units:

99263 x 99 units

99263 x 98 units

J9263 x 97 units

J9263 x 6 units

Q16. The payment amount for J9100 (Cytarabine, 100 mg) when infused through pump seems low. It should be higher than the office payment, as it is for J9100 (Cytarabine, 500 mg).

\*A. The stated payment amount of \$3.19 for J9100 when infused through a pump should be \$8.19. We have advised CMS of the typographical error.

Q17. The pricing differential between J2352 and J2353 for octreotide acetate is unclear.

A. When the 2004 drug payment rates were initially posted by CMS on December 29, 2004, a payment rate was published for J2352. However, HCPCS code J2352 has been deleted for 2004. Octreotide acetate should be coded as follows (payment rates in parentheses):

J2353 Octreotide, depot for IM injection, 1 mg (\$71.09)

J2354 Octreotide, depot for subcutaneous/IV injection, 25 mcg (\$3.94)

Q18. If drug prices end up increasing because manufacturers/others demonstrate to CMS that purchase prices are higher than Medicare payment rates, will changes made to April 1, 2004 prices be retroactive to January 1?

\*A. CMS has advised ASCO that it believes that it does not have the legal authority to make the April 1 payment increases retroactive.

## General

- Q19. The local Medicare carrier states that they have no knowledge of the new policy to pay for multiple pushes and that they will reject claims for multiple pushes.
- \*A. By now, carriers should recognize claims for multiple pushes. If you are experiencing coverage problems provide Medicare's Program Transmittal34. A link to the document can be found in FAQ 2 above.
- Q20. Where can the new fee schedule payment rates be found?
- A. The relative values, geographical adjustment factors, and conversion factor were published in the Federal Register on January 7, 2004. You should check your Medicare carrier's website for the rates that apply specifically to your geographic location.
- Q21. Will the increases in practice expense payments really make up for 100% of the reductions in drug payments?
- A. CMS states in the interim final rule that reductions in drug payments will be offset by equal increases in payments for drug administration services. ASCO is currently analyzing the changes to determine whether a 100% offset is expected actually to occur.
- Q22. How will changes in the drug payment rates and fee schedule affect Medicare + Choice payments?
- A. The Medicare bill increases the payment amount to Medicare+ Choice (now called Medicare Advantage) plans to 100% of what Medicare would have paid in its fee-for-service program. This change is effective in 2004. We believe that in making this calculation, CMS would take the revised payments for drugs and drug administration services into account, although CMS has stated that, at least in the case of oncologists, there is no net financial difference.