

ONCOLOGY & HEMATOLOGY

CODING ALERT

Your practical adviser for ethically optimizing coding, payment, and efficiency in oncology and hematology practices

2010, Vol. 12, No. 4 (Pages 25-32)

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Center Your Focus on Cyclophosphamide for Better Breast Cancer Coding

► **Watch out: The 'T' in TC may not stand for what you think.**

In recognition of National Women's Health Week (May 9-15), give your breast cancer chemotherapy coding a check-up. Below are details on coding several common regimens that include chemotherapy drug cyclophosphamide, and some breast neoplasm ICD-9 essentials to boot.

Keep in mind: In the world of chemotherapy drug coding, you should "never assume anything. You could be wrong," warns **Shelly Noll, CPC**, who works in oncology, hematology, and radiation for Rockwood Clinic in Spokane, Wash. If you can't tell by the notes what a drug is, an auditor can't either, says Noll. That could set you up for audit trouble, so you want to be sure the documentation and coding are first rate.

Assess Lengthy Cyclophosphamide Code Range

If you turn to the table of drugs in your HCPCS manual, you'll see a large range of coding options for intravenous cyclophosphamide (sold as Cytoxan or Neosar). All the codes from J9070 (*Cyclophosphamide, 100 mg*) to J9097 (*Cyclophosphamide, lyophilized, 2.0 gram*) describe cyclophosphamide, says Noll.

To choose the proper code, you must have documentation of the exact drug, stresses Noll. "Was it cyclophosphamide or cyclophosphamide lyophilized? Both are cyclophosphamide," but you use different drug codes for them, Noll explains. *Term tip:* Lyophilized means freeze-dried.

Selecting the proper code also depends on the amount administered, Noll says. The cyclophosphamide code definitions differ based on the amount of drug, as this table shows:

Amount	Cyclophosphamide	Cyclophosphamide Lyophilized
100 mg	J9070	J9093
200 mg	J9080	J9094
500 mg	J9090	J9095
1 g	J9091	J9096
2 g	J9092	J9097

Example: Suppose your documentation shows administration of 400 mg of non-lyophilized cyclophosphamide. You should report two units of J9080 (*Cyclophosphamide, 200 mg*).

Start With AC and J9000

AC: One regimen you may see the oncologist prescribe fairly often is the AC (or CA) regimen. The letters stand for cyclophosphamide and another chemotherapy drug, Adriamycin (doxorubicin).

When the time arrives to code the “A” (Adriamycin/doxorubicin) part of the CA regimen, you’ll have fewer options to ponder than for the cyclophosphamide. HCPCS shows J9000 (*Injection, doxorubicin hydrochloride, 10 mg*) and J9001 (*Injection, doxorubicin hydrochloride, all lipid formulations, 10 mg*) for doxorubicin, Noll says.

The key to choosing between them is determining whether the provider administered the lipid formulation, she adds. The lipid formulation (J9001, sold as Doxil) is intended for ovarian cancer, according to the manufacturer. So J9000 is more likely to be the correct choice. But cancer treatments are constantly developing, so always base your code choice on the services and supplies documented.

Focus on J9190 for 5-FU Regimens

Several breast cancer regimens combine cyclophosphamide and chemotherapy drug 5-fluorouracil (5-FU), sold under the name Adrucil. You should assign J9190 (*Injection, fluorouracil, 500 mg*) for 5-FU, Noll says.

CAF/FAC: Both the CAF and FAC regimens involve Cytoxan (cyclophosphamide) and Adriamycin (doxorubicin), like the CA regimen discussed above, but the regimens add 5-FU to the cocktail. CAF and FAC may differ in doses and frequency of administration.

CMF: Another alternative you might see is CMF: cyclophosphamide, methotrexate, and 5-FU. For chemotherapy drug methotrexate, non-oral, choose between J9250 (*Methotrexate sodium, 5 mg*) and J9260 (*Methotrexate sodium, 50 mg*), based on the dose administered.

FEC/FECD: Finally, for the FEC (or CEF) variation, the nurse administers epirubicin at the same encounter as 5-FU and cyclophosphamide. Your practice should report the chemotherapy drug epirubicin, sold as Ellence, using J9178 (*Injection, epirubicin HCL, 2 mg*). The oncologist may also choose to follow the FEC cycles with cycles of docetaxel therapy. You may see this regimen called FECD. For the docetaxel (Taxotere) report J9171 (*Injection, docetaxel, 1 mg*).

Be sure to watch your units because HCPCS revised your docetaxel coding choice in 2010. You reported the previous code (J9170, *Injection, docetaxel, 20 mg*) once for every 20 mg. You report the new code, J9171, once for every 1 mg.

Take Time to ID ‘T’ in TC

AC+T/ACT: You may see docetaxel (Taxotere) prescribed in breast cancer regimens other than FECD. For

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We would love to hear from you. Please send your comments, questions, tips, cases, and suggestions for articles related to Oncology & Hematology coding and reimbursement to the Editor indicated below.

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some patients, the oncologist may add Taxotere to the AC regimen. AC+T usually refers to an AC cycle followed by a Taxotere cycle. TAC or ACT instead tends to mean the nurse administers the three drugs at the same encounter.

TC: As another alternative, for the TC regimen, the oncologist may prescribe Taxotere and cyclophosphamide, without Adriamycin.

Name check: The “T” may also refer to Taxol. Assign J9265 (*Injection, paclitaxel, 30 mg*) for this drug, which is also sold under the names Onxol and Nov-Onxol.

Any time you aren’t sure about a drug, “verify the drug with the nursing staff or a pharmacy tech, if necessary,” says Noll.

Complete the Coding Puzzle: ICD-9+CPT

All of the drugs discussed above are chemotherapy drugs, and therefore you should pair them with chemotherapy administration codes 96401-96549.

For the diagnosis, keep these codes in mind, but base your choice on the documentation:

- 174.x — *Malignant neoplasm of female breast ...*
- 233.0 — *Carcinoma in situ of breast.*

“Malignant neoplasms are cancerous, and may be noninvasive (in situ), or invasive,” explains **R.M. Stainton Jr., MD**, president of Doctors’ Anatomic Pathology Services in Jonesboro, Ark. ICD-9 further subdivides invasive cancers as “primary,” meaning that the cancer arises from surrounding cells, or “secondary,” meaning that the cancer metastasized (spread) from a primary malignancy located elsewhere in the body.

Secondary malignant neoplasm of breast (198.81, *Secondary malignant neoplasm of other specified sites; breast*) means the primary tumor is somewhere else and metastasized to the breast. If instead the treatment is directed at cancer that metastasized *from* the breast, code for that location, such as 196.3 (*Secondary and unspecified malignant neoplasm of lymph nodes; Lymph nodes of axilla and upper limb*). □

Part 2:

3 More FAQs Take Your 77427 Coding to the Next Level

► *Put this handy chart to work tracking your weekly management visits.*

Understanding 77427 is a key element of keeping your radiation coding on track. Frequently Asked Questions digging into the truth behind the term “weekly” management, the effect of twice daily treatment on your coding, and how to report three to four additional fractions all got answered in last issue’s “Part 1: 3 FAQs Clear Up the 77427 5-Fraction Mystery.”

Now, FAQs 4, 5, and 6 help you steer clear of tempting coding mistakes and make sure you have your documentation ducks in a row.

4. Is 77431 Correct for 1 to 2 Fractions?

You may report 77427 (*Radiation treatment management, five treatments*) once for every five treatment fractions. If the patient completes treatment and has three or four final treatments beyond a multiple of five, you may report one unit of 77427 for those final three or four fractions. You should not report 77427 for one or two final fractions, however.

You also should never report 77431 (*Radiation therapy management with complete course of therapy consisting of*

(Continued on next page)

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one or two fractions only) for the last one or two fractions in a long course of therapy, says **Deborah I. Churchill**, president of Killingworth, Conn.-based Churchill Consulting Inc.

Only report 77431 if the entire course of treatment consists of one or two fractions, and you are not reporting a stereotactic case, says **Scott Plemmons, RT(R)(T)**, senior consultant with Revenue Cycle Inc. in Austin, Texas.

Support: A CPT note with 77431 states “77431 is not to be used to fill in the last week of a long course of therapy.” And for stereotactic treatment management, CPT offers more specific codes: 77432 (*Stereotactic radiation treatment management of cranial lesion[s] [complete course of treatment consisting of 1 session]*) and 77435 (*Stereotactic body radiation therapy, treatment management, per treatment course, to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions*).

Caution: If you’ve sent in claims indicating the treatment course has ended but treatments resume, CMS instructs contractors to pay for additional services as if the break had not occurred. That means that if a patient resumes treatment and has one or two additional fractions, you again should not report 77431.

Example: You reported 77427 twice for eight fractions, which the oncologist expected to complete the course of therapy. But then the same physician decides to furnish two additional fractions. Contractors should not pay separately for the two additional fractions, states *Medicare Claims Processing Manual* (MCPM), Chapter 13, Section 70.1.

5. What Does 77427 Cover?

There are four elements to 77427, according to the American Society for Radiation Oncology (ASTRO), the American College of Radiation Oncology (ACRO), and the American Medical Association (AMA), says Plemmons:

1. Review of port films
2. Review of dosimetry and chart prescription (dose delivery and treatment parameters)
3. Review of the patient’s treatment set-up
4. Examination of the patient for medical evaluation and case management.

CPT specifies that the examination includes assessing the patient response to treatment, coordinating care and treatment, and reviewing imaging or lab results.

“This code also requires a documented face-to-face encounter with the patient,” says Plemmons. For more on this requirement, see the next section.

6. How Many Visits Must the MD Make?

The radiation therapist doesn’t have to examine the patient during each fraction for you to receive 77427 reimbursement, says the *MCPM*. But you do need a progress note in the record for the five-fraction date span (treatment “week”), says Plemmons.

“When the radiation oncologist sees a patient, it is the radiation oncologist’s responsibility to document that encounter via a progress note, which will become part of the patient’s medical record,” Churchill says. “The weekly progress note, commonly referred to as the OTV (on treatment visit note) should include the date of the visit, the current dose, exam, symptoms, orders, etc.,” she says. The oncologist should also document a recommendation, such as “continue as planned,” says Churchill.

Because you can report 77427 only if you have a documented physician progress note within the “week” (five-fraction period), a five-fraction grid is a “great tool to assist the coder in determining when a ‘week’ is reportable,” says Churchill. Remember that to report 77427 you need three or more “days” in the final week, with a progress note available, she adds.

Here is a sample chart, provided by Churchill:

Week	Date From	Date To	Date Seen	Date Progress Note	Date Billed
1					
2					
3					
4					

Correction: In *Oncology & Hematology Coding Alert*, Vol. 12, No. 3, “3 FAQs Clear Up the 77427 5-Fraction Mystery,” the chart indicated below should reflect a total of four units for 18 fractions, as stated in the article text. The corrected chart with preceding text follows:

Because you may report an additional unit for 3 fractions beyond a multiple of 5 (in this case, 15), you should report an additional unit for a total of 4 units:

Unit 1	5 Fractions
Unit 2	5 Fractions
Unit 3	5 Fractions
Unit 4	3 Fractions
Total = 4 Units	Total = 18 Fractions

In the “Date From” column, put the date the patient had the first treatment in the five-fraction week, and in the “Date To” column, note the date of the last fraction in the “week.” For example, if the patient received treatment on a Wednesday, Thursday, Friday, Monday, and Tuesday, you would enter the Wednesday date in the “Date From” column and the Tuesday date in the “Date To” column. Then you can quickly assess whether the dates of the visit (“Date Seen”) and the “Progress Note” date fall within the five-fraction week. □

News You Can Use:

Keep Signature, Modifier 59, and ‘Incident To’ Guidelines Front and Center

► **2 compliance updates keep your coding in the clear.**

If you’ve been worrying that the oncologist’s illegible signature on an order is going to come back to haunt your practice in an audit, CMS has offered answers on when you’re safe and when that untidy scrawl could have reviewers requesting additional information.

1. Get Signature Guidelines Down Pat

With few exceptions, Medicare requires a signature for services and orders. CMS updated the rules and added e-prescribing language to the mix in Transmittal 327, CR6698 (www.cms.gov/transmittals/downloads/R327PI.pdf). The rules instruct contractors reviewing claims on what counts as a signature and when the services or orders must have signatures.

One important exception to the signature requirement is that “diagnostic orders need not be signed by the physician,” says **Kelly Loya, CPC-I, CPhT**, consultant with California-based Sinaiko Healthcare Consulting Inc. Still, the medical record must include information verifying the ordering physician intended the test to be performed, and “a progress note in the medical record must be signed,” Loya explains.

A helpful feature of the transmittal is a chart that “gives very specific facts as to what meets the requirements or requires follow up with the provider to meet the requirements,” says Loya. For example, if you scan the chart, you can quickly see that an illegible signature written

above a typed name is OK, but contractors won’t count just an unsigned typed note with a typed name. “The reviewer can explore alternate methods in order to verify the signature requirement,” Loya notes. But be warned: “Not complying with an attestation request (within 20 days of the request)” could lead to a denial, she says.

If you’ve been reporting G8553 (*At least one prescription created during the encounter was generated and transmitted electronically using a qualified ERX system*), be sure to give the transmittal a close look. The new e-prescribing language solidifies that for non-controlled substances, “as long as a ‘qualified’ e-prescribing system (per Medicare Part D requirements) is used, a pen and ink copy” of the signed prescription order is not required, Loya says. But physicians can’t e-prescribe controlled substances — for example, addictive pain medications — so CMS requires a pen and ink order for these.

Watch for change: The Drug Enforcement Agency recently released its interim final rule on e-prescribing controlled substances. If your oncologist is willing to jump through the multi-step authentication hoops, e-prescribing controlled substances may be a possibility in the future.

Transmittal 327 is effective March 1 with an April 16 implementation date.

2. OIG Is Watching Mod 59; Are You?

In other news, the OIG released its 202-page “Compendium of Unimplemented OIG Recommendations,” which revealed that many OIG suggestions have been ignored (download it here: <http://oig.hhs.gov/publications/compendium.asp>).

Case in point: In 2003, the OIG found a 40-percent error rate on claims that contained modifier 59 (*Distinct procedural service*) when used to separate Correct Coding

(Continued on next page)

You Be the Coder

Decipher This Decitabine Case

Question: *We’re a freestanding facility. How should I report a 61-minute infusion of decitabine for a patient with refractory anemia?*

California Subscriber

Answer: See page 31. □

Initiative (CCI) edits, resulting in Medicare paying \$59 million in improper payments.

The OIG encouraged carriers to institute prepayment and postpayment reviews of the use of modifier 59, and suggested that CMS should update carriers' claims processing systems so they pay claims with modifier 59 "only when the modifier is billed with the correct code," the OIG report indicates. The OIG now says that CMS has not yet instituted such system edits, and notes that it will "continue to monitor CMS's efforts to implement edits to ensure correct coding."

What this means: "The OIG lists modifier 59 as a priority nearly every year, and it's possible that the agency feels that CMS should be looking more closely at its use," says **Randall Karpf** with East Billing in East Hartford, Conn. "The bottom line is that if all of these entities are watching modifier 59, make sure you're using it properly."

In particular, past OIG investigations have shown that one of the more common modifier 59 mistakes is incorrectly unbundling 38220 (*Bone marrow; aspiration only*) and 38221 (... *biopsy, needle, or trocar*), so be sure you keep a careful eye on this code pair. (For more information on these codes, see "Bone Up on 38220, 38221, and G0364: CMS Coding Guidelines in Focus" in *Oncology & Hematology Coding Alert*, Vol. 12, No. 1.)

Plus: The OIG examined services billed using the "incident to" guidelines, which you should know well if you report oncology services to Medicare. As a result of the OIG scrutiny, CMS is revising its incident-to policies to reflect the fact that "no one except licensed physicians perform the services or nonphysicians who have the necessary training, certification, and/or licensure, pursuant to state laws, state regulations, and Medicare regulations perform the services under the direct supervision of a licensed physician."

Although many practices already follow this rule, the OIG "wants an explicit rule rather than the current implicit rule," says **Quinten A. Buechner, MS, MDiv, CPC, ACSFP/ GI/PEDS, PCS, CCP, CMSCS**, president of ProActive Consultants in Cumberland, Wis. □

READER QUESTIONS

Zero In on Xerostomia Coding

Question: *If we provide amifostine for a lip cancer patient receiving radiation, which diagnosis codes should we report?*

Florida Subscriber

Answer: For many payers, reporting the radiation encounter (V58.0, *Encounter for other and unspecified procedures and aftercare; radiotherapy*) and the appropriate neoplasm code (140.x, *Malignant neoplasm of lip*) will suffice to prove amifostine (J0207, *Injection, amifostine, 500 mg*) medically necessary.

Check your payer policies to get the final word on which codes — supported by your documentation — the payer requires on the claim for payment. For example, the First Coast Service Options local coverage determination (LCD) for amifostine (L29059) states that Medicare will consider amifostine medically reasonable and necessary "to reduce the incidence of moderate to severe xerostomia in patients undergoing radiation treatment for head and neck cancers where the radiation port includes a substantial portion of the parotid gland."

In addition to the appropriate head and neck cancer codes, other codes payers may request for radiation patients include:

- 527.7 — *Disturbance of salivary secretion*
- 909.2 — *Late effect of radiation*.

Xerostomia: Radiation therapy can damage salivary glands, causing head and neck cancer patients to experience dry mouth (xerostomia). Amifostine helps protect normal salivary gland cells from the radiation's effects.

Append Modifier Q6 for Fill-In Physician

Question: *We hired a locum tenens for two weeks. Do we code the same for the replacement physician as for a full-time oncologist?*

Georgia Subscriber

Answer: Private payer rules may vary, but for Medicare patients, you should append modifier Q6 (*Service furnished by a locum tenens physician*) to each procedure code on the temporary doctor's Medicare claims. You should bill under the national provider identifier (NPI) of the physician the locum is replacing.

Although your two-week arrangement falls well inside Medicare's 60-day limit for a locum tenens physician, you should be aware that a substitute physician may not provide services to Medicare patients for more than 60 days, according to the *Medicare Claims Processing Manual*, Chapter 1, Section 30.2.11. (See additional details in the manual, online at www.cms.hhs.gov/manuals/downloads/clm104c01.pdf.)

Private payers vary: Before using modifier Q6 for a non-Medicare patient, check with the commercial payer.

Some will follow the Medicare locum tenens guidelines, but you should not assume that all commercial payers will want modifier Q6. Private payers' rules regarding substitute physicians can differ from Medicare's.

Definition: A locum tenens arrangement describes a one-way exchange between physicians, in which your oncologist or hematologist retains a substitute physician (the locum tenens) to take over the practice temporarily and pays the substitute physician a fixed amount per diem or similar fee-for-time structure. Reasons for hiring a locum tenens may include the regular physician needing time away for illness, pregnancy, vacation, or continuing medical education.



Remember +99354 30-Minute Minimum

Question: *The oncologist documented 60 minutes for an established patient office visit. She documented spending more than half the time on counseling because they were discussing treatment regimen options and the patient had many questions. Should I code this as 99214 for the first 25 minutes and +99354 for the remaining time?*

Minnesota Subscriber

Answer: No. When counseling and/or coordination of care represents more than 50 percent of the total time with the patient, CPT guidelines instruct that you may choose the E/M level based on time. You should assign 99215 (*Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a comprehensive history; a comprehensive examination; medical decision making of high complexity ... Physicians typically spend 40 minutes face-to-face with the patient and/or family*) for this office visit.

How it works: When the physician spends more than 50 percent of an E/M service on counseling and/or coordination of care in a face-to-face encounter, select an E/M code based on the typical/average time associated with the code levels, reports the *Medicare Claims Processing Manual (MCPM)*, Chapter 12, Section 30.6.15.1.H. The documented time must meet or exceed the typical/average time associated with the E/M code you report (as stated in the code definition).

For instance: The *MCPM* offers an example of a physician providing a subsequent office visit that was predominantly counseling, spending 60 minutes (face-to-face) with the patient. The physician must not code +99354 (*Prolonged physician service ...*) and 99214 (which has a typical time of 25 minutes). The physician

must bill the highest level code in the code family (99215, which is associated with 40 minutes typical/average time units). For a 60-minute visit, the additional time the physician spends beyond 99215's 40 minutes is 20 minutes, which does not meet the 30-minute

(Continued on next page)

You Be the Coder

Decipher This Decitabine Case

(Question on page 29)

Answer: Decitabine is an antineoplastic drug, so unless your payer tells you otherwise in writing, you should report 96413 (*Chemotherapy administration, intravenous infusion technique; up to 1 hour, single or initial substance/drug*) for the 61-minute infusion. Some payers may maintain that decitabine does not merit a chemotherapy administration drug and may ask for a code such as 96365 (*Intravenous infusion, for therapy, prophylaxis, or diagnosis [specify substance or drug]; initial, up to 1 hour*) instead. (The OIG noted this confusing reality in a 2009 report available at <http://oig.hhs.gov/oei/reports/oei-09-08-00190.pdf>.)

HCPCS: Don't forget to report the drug (sold under the name Dacogen) using J0894 (*Injection, decitabine, 1 mg*). The entity bearing the cost of the drug should be the one to report it.

ICD-9: For the diagnosis coding, depending on payer guidelines, report V58.11 (*Encounter for antineoplastic chemotherapy*) as your first-listed diagnosis (assuming the infusion was the reason for the visit). You should then code the refractory anemia (RA) to 238.72 (*Low grade myelodysplastic syndrome lesions*). ICD-9 includes a number of diagnoses under this code:

- RA with excess blasts-1 (RAEB-1)
- RA with ringed sideroblasts (RARS)
- refractory cytopenia with multilineage dysplasia (RCMD)
- refractory cytopenia with multilineage dysplasia and ringed sideroblasts (RCMD-RS).

Note that ICD-9 used to include RAEB-1 under 238.73 (*High grade myelodysplastic syndrome lesions*) alongside RAEB-2, but now the manual lists only RAEB-2 under 238.73. □

minimum CPT guidelines indicate +99354 requires. So you should not report a prolonged service code in this situation.

Limit Yourself to 1 Unit of 77418

Question: *If the oncologist treats multiple fields using IMRT in a single session, should I report more than one unit of 77418?*

Colorado Subscriber

Answer: No. You should report 77418 (*Intensity modulated treatment delivery, single or multiple fields/arcs, via narrow spatially and temporally modulated beams, binary, dynamic MLC, per treatment session*) once per session. The code definition specifies that the code applies to “single or multiple fields/arcs ... per session.”

CPT Assistant (March 2010) addresses a similar question in its Coding Consultation section and explains that reporting 77418 more than once per session would be inappropriate.

Smart move: Take extra care to be sure you’re reporting 77418 properly. A Florida physician group recently agreed (without admitting wrong-doing) to pay the government \$12 million to settle a case involving fraud allegations, including the use of IMRT in cases when the government maintains lower-priced standard radiation treatment would have worked just as well. With such a high-profile case in the news, there’s a good chance auditors will be keeping an eye out for IMRT coding mistakes. You can do your part by being sure your coding accurately reflects the documentation. (The Department of Justice press release on the case is available at www.justice.gov/opa/pr/2010/March/10-civ-299.html.)

— *Clinical and coding expertise for You Be the Coder and Reader*

Questions provided by **Kelly C. Loya, CPC-I, CPhT**, senior consultant with Los Angeles-based *Sinaiko Healthcare Consulting Inc.* □

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