



ACCC **2023**  
Oncology  
Reimbursement  
MEETINGS

Top 10 Common Errors  
& Underutilized Codes




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**Teri Bedard, BA, R.T.(R)(T), CPC**  
*Executive Director, Client & Corporate Resources  
Revenue Cycle Coding Strategies*  
[Teri.Bedard@RCCSinc.com](mailto:Teri.Bedard@RCCSinc.com)

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## Common Errors & Missed Opportunities



### Errors

- Diagnosis code
  - Incorrect
  - Unspecified
  - Missing covered diagnosis
- Claims issues
  - Modifiers
  - Bundled services billed
  - Code combinations
- Process errors
  - Lack of authorization
  - Claim submission time limit expired
  - Outdated chargemasters
  - Editing software errors, not updated


### Missed Opportunities

- Additional services at time of E/M
- Clinic visits in hospital
- Procedure codes billed by physician & hospital

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# Common Errors



Association of Community Cancer Centers

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## Diagnosis Coding Issues




Lack of specificity	Missing covered diagnosis
Sequence of codes	Primary vs. Secondary

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## Specificity




### ICD-10 Coding Guidelines

“A joint effort between the healthcare provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures. **The importance of consistent, complete documentation in the medical record cannot be overemphasized.** *Without such documentation accurate coding cannot be achieved.* The entire record should be reviewed to determine the specific reason for the encounter and the conditions treated.”<sup>1</sup>

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## Coding for the Encounter



**First-Listed Code**

“...diagnosis, condition, problem or other reason for encounter/visit shown in the medical record to be chiefly responsible for the services provided”<sup>2</sup>

**Other Diagnoses**


“Code all documented conditions that coexist at the time of the encounter/visit and require or affect patient care treatment or management.”<sup>2</sup>

Do not forget metastatic lymph nodes with primary neoplasm! The mets may be the diagnosis covered for the selected modality.

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## Secondary Malignancies



- If active primary and secondary neoplasms – code primary first
- If treatment directed to secondary site only – code secondary first


A patient with prostate cancer is diagnosed with bone metastasis to the femur and spine and the patient is seen by the oncologist for potential bisphosphonate treatment.

- **C79.51** Secondary malignant neoplasm of bone
- **C61** Malignant neoplasm of prostate

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## Personal History



The physician documents in the medical record the patient has "history of" the cancer.

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02 The primary site is no longer being treated; and

01 The primary site is excised/eradicated; and



03 There is no evidence of remaining cancer at the primary site; and

Assign a code for personal history of neoplasm only when:

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## Drug Waste





While providers performing drug administration make every effort to ensure that all drugs are correctly delivered as required by package insert, State law and in compliance with regulatory guidelines, sometimes it is still necessary to discard the remaining drug amount in a single dose vial or package.


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## Waste Rules




 Overfill not billed as waste

 *MLN Matters SE1316* "The units billed must correspond with the smallest dose (vial) available for purchase from the manufacturer(s) that could provide the appropriate dose for the patient."<sup>3</sup>

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## Modifier JW




<p>Applicable when provider administers part of a single-use vial and remainder is discarded</p>	<p>Medicare will reimburse for amount administered and amount wasted</p>
<p>Utilized for physician office and hospital outpatient settings</p>	<p>Review payer contracts and policies for commercial insurers</p>

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## Smallest Vial Size



Smallest vial manufactured should be used for billing, not the smallest vial present in the facility


### Example

- If the drug amount to be given is 100mg and vials come in 250mg and 500mg, it is appropriate to bill from the 250mg vial
- The amount of drug discarded is 150mg, not 400mg

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## Modifier JW Example



A Medicare patient is prescribed 90.6 mg of Taxotere (docetaxel), which is available in a 20 mg single use vial or an 80 mg single use vial. The hospital only stocks the 80 mg vials and administered + wasted a total of 160 mg. This claim would be submitted as follows for HCPCS code J9171 (injection, docetaxel, 1 mg):



- Claim line #1: J9171, 91 units (91 mg), for the 90.6 mg administered to the patient
- Claim line #2: J9171-JW, 9 units (9.4 mg), for the discarded drug amount

**Note:** *The drug administered to the patient is correctly reported as 91 mg; there is no mechanism to report “partial” mgs of this drug. Also, Medicare requires that drugs be billed based on the smallest single-dose vial size available.*

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## Modifier JZ




- Used to attest no discarded amounts for a particular drug
- Implementation delayed for 6 months to allow for claims system updates (July 1, 2023)
- If not able to report modifier by October 1, 2023, CMS instructs to hold claims
- Claims lacking modifier will be returned as non-processable

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## Modifier JZ Example



Bevacizumab: J9035 (1 unit per 10 mg)

If a patient is given 1000 mg from two 400 mg and two 100 mg single use vials (total 1000 mg), there is no drug waste, the provider should report the following:

**J9035-JZ x 100 units (administered 1000 mg)**


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## Modifier Sequence



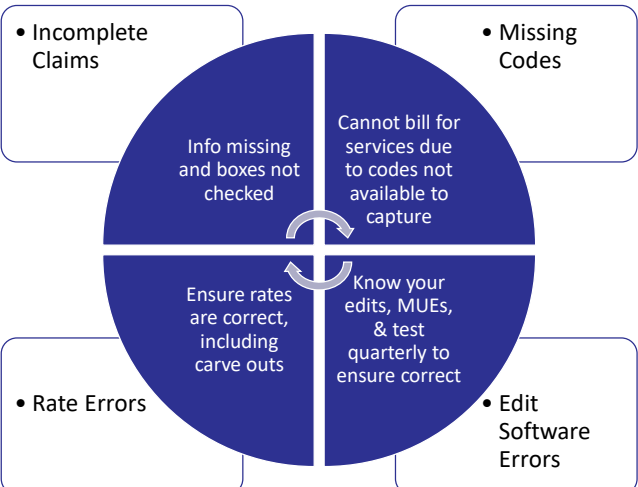
Payment	Informational	Examples when applicable
<ul style="list-style-type: none"> <li>List first when there are multiple modifiers</li> <li>Payment modifiers include: 22, 26, 50, 51, 52, 53, 54, 55, 58, 78, 79, AA, AD, TC, QK, QW, and QY</li> </ul>	<ul style="list-style-type: none"> <li>Anything not classified as payment, may also be statistical</li> <li>If multiple informational, order does not matter as long as after payment</li> </ul>	<ul style="list-style-type: none"> <li>Identification of professional or technical only components.</li> <li>Repeat services by the same or different provider.</li> <li>An increased, reduced, or unusual service.</li> <li>Billing for components of a global surgical package.</li> <li>Identification of a specific body area.</li> <li>To designate a bilateral procedure.</li> <li>Identification of service in a clinical trial.</li> </ul>

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## Chargemaster, Edits & Claim Mistakes







MUE = medically unlikely edits

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## Concurrent Infusions



### Start & Stop Times



“Infusion time is calculated from the time the administration commences (i.e., the infusion **starts** dripping) to when it ends (i.e., the infusion **stops** dripping)”<sup>4</sup>

-CMS

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## Medicare Administrative Contractor




“Poor documentation for the line flush between drugs makes it impossible to determine whether compatible substances or drugs were administered concurrently or sequentially”<sup>5</sup>

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## Basic Rules



- One “initial” code is reported per encounter
- Other services are:
  - “sequential”,
  - “each additional” or
  - “concurrent”

### Facility

Defined by hierarchy


### Office

Primary reason for the encounter

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## Hierarchy



### Physician Office/Freestanding

- **Initial service should correspond with the primary reason for the encounter.**
  - Infusion
  - Injection
  - Hydration


### Hospital Outpatient

- **Attention to the type of drug or biological administered.**
  - Chemotherapy Infusion
  - Chemotherapy IV Push
  - Therapeutic / Prophylactic Infusion
  - Therapeutic / Prophylactic IV Push
  - Hydration

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## Time-Based Coding




Infusion Time	Coding
<15 minutes	IV Push
16-90 minutes	Initial hour (hydration requires minimum of 31 minutes)
91-150 minutes	Initial hour + 1 additional hour
151-210 minutes	Initial hour + 2 additional hours
211-270 minutes	Initial hour + 3 additional hours

Same time-based concept applies for additional hours of therapeutic/prophylactic administration and hydration


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## Timely Filing of Claims




- Many commercial payers maintain 60-90 day filing deadlines from DOS
- Medicare deadlines are 12 months from date of service
- Payers vary on their deadlines. It is in the contract.
- Know your claim submission and appeals deadlines
- Some state legislation requires 6 month filing deadlines for all claims



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## Denials Related to Authorizations



- Prior authorization not requested or obtained
- Prior authorization pending, service provided - "I can't wait"
- Prior authorization obtained but for wrong service(s)
- Wrong codes or units, can be eliminated by requesting what is *possible*
- Prior authorization obtained, information not on claim, put information in wrong place in EHR
- Different diagnosis authorized vs. billed

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## Missed Opportunities



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## Additional Procedures at Time of E/M

CPT® Code	Definition
<b>31575</b>	Laryngoscopy, flexible fiberoptic; diagnostic
<b>92511</b>	Nasopharyngoscopy with endoscope (separate procedure)

**Key to code assignment is the anatomy viewed**

Nasopharynx  
Oropharynx  
Laryngopharynx

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## Procedures on Same Date of Service

**Bone marrow biopsy**

**Drug administration**


**Transfusion**

**Medical necessity required to support need for visit separate from procedure**

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## Separately Billable




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“Although CPT code 99211 is not reportable with chemotherapy and non-chemotherapy drug/substance administration HCPCS/CPT codes, other non-facility-based E&M CPT codes (e.g., 99201-99205, 99212-99215) are separately reportable with modifier 25 if the physician provides a significant and separately identifiable E&M service.”<sup>6</sup>

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## Modifier 25



**Commonly misused**


May be utilized for same diagnosis

- “Above and beyond” usual pre/post procedure service
- Distinct problem or reason for the visit
- Separate documentation to support E/M

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## Documentation




Separate documentation of each service (e.g., E/M and procedure) is recommended so that each service is readily and individually identifiable as such

Each may be documented separately in progress or other appropriate notes. Separate pages for each service are not required

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## Facility Clinic Visits



CPT Code	Definition
<b>G0463</b>	Hospital outpatient clinic visit for assessment and management of a patient

Hospital outpatient only

Reimburses for facility overhead and costs

Does not differentiate between new and established


Documentation required




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## Commercial Payers




-  May require codes **99202-99215**  
**New Vs. Established:**  
Seen within the hospital system within a 3-year period
-  Policy needed to assign level of service
-  Documentation to support level

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## Services Billable by Physician *and* Hospital




- Endoscopy procedures
- Placement of brachytherapy applicators
- Placement of fiducial markers & hydrogel
- Bone marrow biopsies & aspirations
- Any kind of multispecialty procedure – higher likelihood

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## Internal Audits




- Audit yourself full cycle – prior authorization to claim submission
- Workbook for prior authorizations – clinical and payer based
- How often and who verifies chargemaster?
- Attend specialty webinars, track code changes
- What are *your* trends?

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## Answering the Denial




**What is your process?**

- Do staff have access, know what to look for, and where to find documentation?
- Utilize appropriate verbiage and terminology
- Check the documentation. Does it exist and is it complete? Signatures?
- Annotate if necessary to identify components to support service(s)
- Ensure all pertinent documentation is submitted timely
- Document who answered the denial and if documentation is submitted

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## Avoiding Future Denials



Check for required authorization for treatment technique

Submit appropriate procedure coding and quantities.  
Ensure to communicate changes to services

Utilize correct diagnosis  
Highest level of specificity  
Metastatic versus primary disease  
Informational codes, (e.g., previous treatment)




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# Questions

Thank you for attending!



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