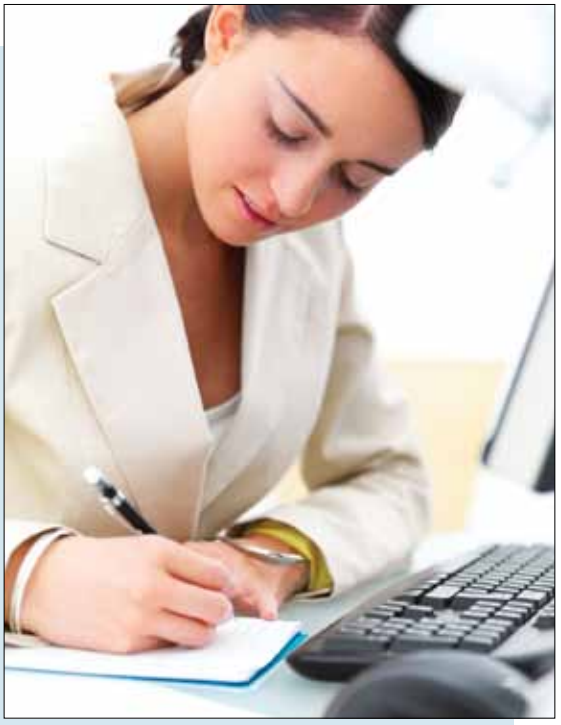
CODING

Oncology Code Update 2010

by Cindy Parman, CPC, CPC-H, RCC



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Another year, another set of coding and billing challenges! Here is a round up of new codes and updated code definitions that will affect medical oncology and radiation oncology in 2010.

New Codes and Updated Descriptors

The CPT® Manual for 2010 includes 27 codes that are listed out of numerical sequence. This change primarily affects a group of new codes for surgical resections; however, oncology codes may be affected in years to come. The AMA stated that this resequencing was necessary "to minimize the disruption that occurs when new codes need to be added in a particular section" and no space is available for them in their logical position. Resequencing will prevent the need for deleting and renumbering entire sections of codes—as has occurred in past years. Codes that appear out of numeric sequence will be flagged with the pound sign (#) and a cross-reference note will appear in the code's correct numeric position indicating where the code is located.

With respect to new procedure codes, three codes have been added for placement of fiducial markers:

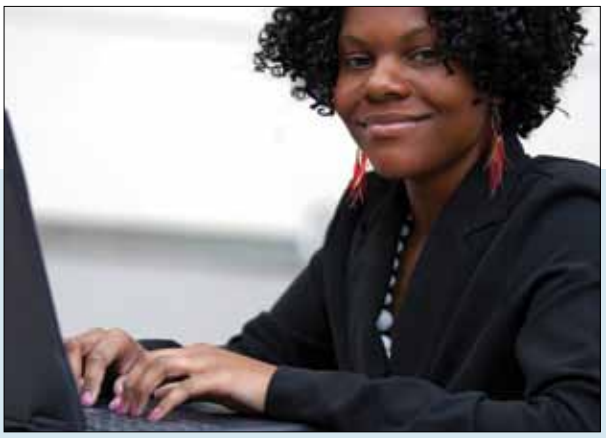
- **31626:** Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of fiducial markers, single or multiple.
- **32553:** Placement of interstitial device(s) for radiation therapy guidance (e.g., fiducial markers, dosimeter), percutaneous, intrathoracic, single or multiple.
- **49411:** Placement of interstitial device(s) for radiation therapy guidance (e.g., fiducial markers, dosimeter), percutaneous, intra-abdominal, intra-pelvic (except prostate), and/or retroperitoneum, single or multiple.

Code **31626** is used for bronchoscopic marker placement, and as indicated, this procedure includes fluoroscopic guidance (if used). Codes **32553** and **49411** are used for percutaneous placement of interstitial markers or dosimeters in the thorax and pelvis or retroperitoneum, respectively. Each code is reported once regardless of how many markers or dosimeters are placed in that area. If imaging guidance is used for the percutaneous placement of markers, it should be separately reported with code **76942** (ultrasound), **77002** (fluoroscopy), **77012** (CT), or **77021** (MRI). Remember that all image guidance is packaged in the outpatient

Table 1. Agents with new HCPCS codes for 2010*

New 2010 Code		Deleted 2009 Code	
C9257	Injection, bevacizumab, 0.25 mg	**Q2024**	Injection, bevacizumab, 0.25 mg
J2562	Injection, plerixafor, 1 mg	**C9252**	Injection, plerixafor, 1 mg
J2796	Injection, romiplostim, 10 mcg	**C9245**	Injection, romiplostim, 10 mcg
J7185	Injection, Factor VIII (antihemophilic factor, recombinant) (Xyntha), per I.U.	**Q2023**	Injection, Factor VIII (antihemophilic factor, recombinant) (Xyntha), per I.U.
J9171	Injection, docetaxel, 1 mg	**J9170**	Injection, docetaxel, 20 mg
J9328	Injection, temozolomide, 1 mg	**C9253**	Injection, temozolomide, 1 mg

*The 2009 codes for these agents have been deleted and replaced with the 2010 codes.



hospital department for Medicare patients. The hospital continues to charge packaged services separately, but Medicare considers the reimbursement included in the payment for other procedures on the same date.

In addition, the existing code for placement of fiducial markers into the prostate has been revised to clarify that it is to be used for *percutaneous* marker placement—**55876:** Placement of interstitial device(s) for radiation therapy guidance (e.g., fiducial markers, dosimeter), percutaneous, prostate, single or multiple.

HCPCS code **C9728**, previously used by hospitals to report placement of fiducial markers in any location other than the prostate, has been revised in light of the new CPT® codes for marker placement. The 2009 definition read as follows: Placement of interstitial device(s) for radiation therapy/surgery guidance (e.g., fiducial markers, dosimeter), other than prostate (any approach), single or multiple. The 2010 definition is now: Placement of interstitial device(s) for radiation therapy/surgery guidance (e.g., fiducial markers, dosimeter), for other than the following sites (any approach): abdomen, pelvis, prostate, retroperitoneum, thorax, single or multiple. In other words, in 2010, hospitals will use code **C9728** for placement of fiducial markers in any location not defined by the surgical procedure codes. Physician practices will use the applicable unlisted procedure code for placement of markers in locations other than the thorax, prostate, abdomen, pelvis, or retroperitoneum.

Existing code **31643** has also been revised to clarify that it includes fluoroscopic guidance (if used). In 2010, providers will use code **31643** for: Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with placement of catheter(s) for intracavitary radioelement application.

A new code has been added for design and construction of a multileaf collimator (MLC) for intensity-modulated radiation therapy (IMRT). In 2010, providers will use code **77338** for: Multileaf collimator (MLC) device(s) for intensity modulated radiation therapy (IMRT), design and construction per IMRT plan. This code can be reported *only once* per IMRT plan, regardless of the number of gantry angles used for treatment delivery and *replaces* code **77334** for the beam-shaping devices. However, the design and construction of immobilization devices for IMRT will continue to be reported separately with codes **77332-77334**. Finally, code **77338** should *not be* reported in conjunction with compensator-based IMRT (code **0073T**).

Effective Jan. 1, 2010, the code for Cobalt-60 stereotactic radiosurgery (SRS) treatment delivery has been designated as including moderate sedation. As a result, moderate sedation should not be separately coded when performed with Cobalt-60 radiosurgery. Instead, providers should use code **77371:** Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; multi-source Cobalt 60 based.

A Category III code for intrafraction localization was implemented on Jan. 1, 2009, but is appearing for the first time in the 2010 *CPT® Manual*. This code is **0197T:** Intra-fraction localization and tracking of target or patient motion during delivery of radiation therapy (e.g., 3D positional tracking, gating, 3D surface tracking), each fraction of treatment.

CMS has established a new HCPCS Level II "per treatment dose" code for Quadramet (Sm-153 lexidronamm): **A9604**: Samarium Sm-153 lexidronamm, therapeutic, per treatment dose, up to 150 millicuries. This code replaces **A9605** (Samarium Sm-153 lexidronamm, therapeutic, per 50 millicuries). Remember to educate all personnel responsible for charge capture that the unit dose has changed.

The following new codes have been established for hematology and oncology drugs:

- **J1680:** Injection, human fibrinogen concentrate, 100 mg.
- **J9155**: Injection, degarelix, 1 mg.
- **Q0138**: Injection, ferumoxytol for treatment of iron deficiency anemia, 1 mg (non-ESRD use).
- **Q0139**: Injection, ferumoxytol for treatment of iron deficiency anemia, 1 mg (for ESRD on dialysis).

Table 1 shows agents with new HCPCS codes for 2010. The 2009 codes for these agents have been deleted and replaced with the 2010 codes.

Last, for 2010, the definition of code **J7192** is now: Factor VIII (antihemophilic factor, recombinant) per I.U., not otherwise specified. This is a change from the 2009 definition: Factor VIII (antihemophilic factor, recombinant) per I.U.

Remember that the existence of a procedure or supply code *does not* guarantee reimbursement; payment for a service depends on the patient's insurance policy, medical necessity, and other determining factors.

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Physician Practice and Freestanding Center Regulatory Update

by Cindy Parman, CPC, CPC-H, RCC

In the Medicare Physician Fee Schedule (MPFS) final rule for 2010, CMS finalized the policy to remove physician-administered drugs from the definition of "physician services" for purposes of computing the physician update formula. In addition, CMS is removing drugs from the calculation of allowed and actual expenditures retrospectively to the 1996-1997 base year to eliminate the disproportionate impact that the large past increases in the costs attributable to physician-administered drugs would otherwise have upon future MPFS updates. Further, this policy will remove drugs from the calculation of the Sustainable Growth Rate (SGR) beginning with calendar year 2010.

In the 2010 MPFS proposed rule, CMS noted that the agency had received comments regarding the practice expense direct cost inputs (for example, supply costs and the useful life of the renewable sources) related to several high-dose-rate radiation therapy (HDR) and placement codes (CPT **77785-77787**). Based on its review of these codes and comments received, the agency requested that the AMA Relative Value Update Committee (RUC) consider these CPT codes for additional review at its October 2009 meeting.

In the 2010 MPFS final rule, CMS reports that the AMA RUC reviewed the HDR brachytherapy CPT codes based on the CMS request and recommended revisions to the clinical labor staff type, supplies, and equipment. The AMA RUC recommended further discussion between the specialty and CMS concerning a resolution regarding the useful life of the Iridium-192 source. The AMA RUC and other commenters stated that the useful life of the Iridium-192 source is 70 to 90 days. However, many commenters stated that physician offices enter into one-year contracts for its replacement.

CMS accepted the AMA RUC's recommendations regarding the

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direct practice expense inputs for HDR brachytherapy codes **77785-77787**. Based on the comments received and further analysis, CMS is changing the useful life of the Iridium-192 source from five years to one year and it will be considered as equipment. CMS is also revising the direct practice expense inputs for clinical labor staff type, supplies, and equipment.

Elimination of Consultation Codes

CMS finalized the proposal to eliminate the use of all consultation codes, which are typically billed by specialists and paid at a higher rate than equivalent evaluation and management (E/M) services. Effective Jan. 1, 2010, practitioners will use existing E/M service codes when providing these services. This budget neutral policy increases the work RVUs for new and established office visits, increases the work RVUs for initial hospital and initial nursing facility visits, and incorporates the increased use of these visits into the practice expense and malpractice RVU calculations.

CMS points out that discontinuing the use of the consultation codes does not imply discontinuing payment for consultation services, but only discontinuing the payment differential between consultations and visits. These services will continue to be reported, coded, and paid under the PFS using the new (codes **99201-99205**) and established (codes **99211-99215**) office visit E/M codes. A number of unanswered questions remain relating to the reporting of visits in the absence of consultation codes, and CMS plans to issue additional instructions during CY 2010.

In addition, the Evaluation and Management Services Guidelines listed in the CPT® Manual have been expanded to include information on transfer of care. The guidelines note that: "Consultation codes should not be reported by the physician who has agreed to accept transfer of care before an initial evaluation but are appropriate to report if the decision to accept transfer of care cannot be made until after the initial consultation evaluation, regardless of site of service."

Last, the HCPCS modifier AI—principal physician of record, was added in conjunction with the new Medicare policy on consultations. The "AI" modifier is to be used by the patient's attending physician on the claim for initial hospital care. For example, while the radiation oncologist will report a code from the range **99221-99223** (initial inpatient visit) for the first patient visit in the hospital, only the admitting physician will append modifier AI to indicate that this is the physician of record for the inpatient stay.

E-prescribing

The Medicare Improvement for Patients and Providers Act (MIPPA) established a five-year program of incentive payments to eligible professionals who are successful electronic prescribers (e-prescribers), as defined by the statute. The final rule simplifies the reporting requirements for the e-prescribing prescribing measure, provides eligible professionals with more reporting options, and establishes a new process for group practices to be considered successful electronic prescribers. Eligible professionals or group practices that meet the requirements of each program in 2010 will be eligible for incentive payments for each program equal to 2.0 percent of their total estimated allowed charges for the reporting periods. Radiation oncologists are not currently eligible for e-prescribing incentive payments.

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Hospital Regulatory Update

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Here is a round up of the regulatory changes that will affect medical oncology and radiation oncology in 2010.

Physician Supervision

In the 2010 final HOPPS (Hospital Outpatient Prospective Payment System) rule, CMS again provides clarification of the regulations regarding physician supervision of services performed in a hospital outpatient department. The agency has broadened the rules for supervision of therapeutic procedures in the hospital outpatient setting to permit supervision by midlevel providers, including physician assistants, nurse practitioners, clinical nurse specialists, certified nurse-midwives, and licensed clinical social workers. These practitioners may supervise therapeutic "services that they may perform themselves under their State license and scope of practice and hospital-granted or CAH-granted privileges." In other words, a practitioner may not supervise a service that he or she cannot personally perform.

For therapeutic procedures performed *on a hospital's main campus,* the supervising physician or practitioner must be present "on the same campus." The supervisor may be located anywhere on the campus, including a physician's office, an on-campus skilled nursing facility, or other nonhospital space.

For therapeutic procedures performed *in an off-campus provider-based department (*PBD), the supervising physician or practitioner must be present in the PBD during the procedure.

Regardless of the location, the supervising physician or practitioner must be "immediately available to furnish assistance and direction throughout the performance of the procedure." This definition means that:

1. The supervisor must not be "performing another procedure or service that he or she could not interrupt."
2. The supervisor must not be "so physically far away on the main campus from the location where hospital outpatient services are being furnished that he or she could not intervene right away."
3. The supervisor "must have, within his or her State scope of practice and hospital-granted privileges, the ability to perform the service or procedure." CMS states that it would be inappropriate for a supervising physician or practitioner to be responsible for patients and services that are outside the scope of their knowledge, skills, licensure, or privileges. The supervisor "must be prepared to step in and perform the service, not just respond to an emergency."

Supervision of Diagnostic Services

Different rules apply for supervision of *diagnostic* services, such as diagnostic imaging exams. CMS states: "All hospital outpatient diagnostic services provided directly or under arrangement, whether provided in the hospital, in a PBD of a hospital, or at a nonhospital location, follow the physician supervision requirements for individual tests as listed in the MPFS (Medicare Physician Fee Schedule) Relative Value File." For example, the MPFS RVU file indicates that a head CT with contrast (70460) requires direct physician supervision. Therefore, this exam must be performed under direct physician supervision when it is performed in the hospital radiology department, in a hospital-owned imaging center that is defined as a PBD, or in a physician office under arrangements with the hospital. ("Under arrangements" means that the outside imaging facility bills the hospital for exams it performs on hospital patients.)

CMS has issued the following criteria for physician presence during a diagnostic exam that requires *direct* physician supervision:

- When the exam is performed in the hospital or in an on-campus outpatient department (PBD), the supervising physician "must be present on the same campus." The physician may be located anywhere on the campus, including a physician's office, an on-campus skilled nursing facility, or other nonhospital space.
- When the exam is performed in an off-campus outpatient department (PBD), the supervising physician "must be present in the off-campus PBD."
- When the exam is performed under arrangements in a nonhospital location such as an independent diagnostic testing facility (IDTF) or physician office, the supervising physician must be "present in the office suite."

In addition to the above criteria, the physician must be "immediately available to furnish assistance and direction throughout the performance of the procedure." This definition means the physician must not be performing another procedure that cannot be interrupted, and must not be so physically far away that he or she could not provide timely assistance. Nonphysician practitioners *may not* supervise diagnostic tests provided to hospital outpatients. The required supervision can be provided only by a physician (MD or DO).

Drug Reimbursement

For 2010, separately payable drugs will be reimbursed at ASP+4 percent. At the same time, the agency is increasing the cost allocation for packaged drugs, which are included in the APC payment for associated

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Table 1. Separately Payable Therapeutic Radiopharmaceutical Codes for 2010

HCPCS Code	Definition	APC	Status
A9517	Iodine I-131 sodium iodide capsule(s), therapeutic, per millicurie	1064	K
A9530	Iodine I-131 sodium iodide solution, therapeutic, per millicurie	1150	K
A9543	Yttrium Y-90 ibritumomab tiuxetan, therapeutic, per treatment dose, up to 40 millicuries	1643	K
A9545	Iodine I-131 tositumomab, therapeutic, per treatment dose	1645	K
A9563	Sodium phosphate P-32, therapeutic, per millicurie	1675	K
A9564	Chromic phosphate P-32 suspension, therapeutic, per millicurie	1676	K
A9600	Strontium Sr-89 chloride, therapeutic, per millicurie	0701	K
A9604	Samarium Sm-153 lexidronamm, therapeutic, per treatment dose, up to 150 millicuries	1295	K

procedures, to 171 percent of the ASP, although this change will not result in separate payments for packaged drugs.

In addition, CMS encourages hospitals to use revenue code **0636** for drugs that have HCPCS codes, rather than reporting the costs of these drugs under the pharmacy revenue code (**0250**) without HCPCS codes, as this limits the agency's ability to quantify the costs of specific drugs.

Some drugs are represented by multiple HCPCS codes for different dose levels. CMS notes that for 2010, it will make a single packaging determination that applies to all of a drug's HCPCS codes. Previously CMS made the packaging determination for each individual HCPCS code, and CMS was concerned that this decision would create an incentive to report certain HCPCS codes rather than others for the same drug.

Although CMS has paid for therapeutic radiopharmaceuticals on a cost basis for the past four years, beginning Jan. 1, 2010, Medicare will pay for therapeutic radiopharmaceuticals at 104 percent of the average sales price (ASP), like other drugs and biologicals. The ASP applies to the price of a "patient-ready dose," which includes all component materials of the radiopharmaceutical and any other processing that is required.

Table 2. Hospital Clinic Visit Codes for 2010

APC	Title	Codes
0604	Level 1 Hospital Clinic Visits	99201 99211
0605	Level 2 Hospital Clinic Visits	99202 99212 99213
0606	Level 3 Hospital Clinic Visits	99203 99214
0607	Level 4 Hospital Clinic Visits	99204 99215
0608	Level 5 Hospital Clinic Visits	99205

Radiopharmaceutical manufacturers will not be required to submit ASP data; if CMS does not have ASP data for a radiopharmaceutical, the payment will be based on costs extrapolated from 2008 Medicare claims data. For first quarter 2010, CMS will set payment rates based on ASP if the manufacturer submits ASP data in time. Otherwise, payment rates will be based on costs, and ASP-based pricing will be implemented as data are available. Table 1 lists the separately payable therapeutic radiopharmaceutical codes for 2010.

Codes for Clinic Visits

For 2010, CMS makes no changes to the codes for clinic visits, emergency department visits, and critical care. Commenters again asked CMS to eliminate the distinction between new and established patient clinic visits, but the agency again declined, citing cost differences between the two types of services. CMS continues to define an established patient as one who has been registered as an inpatient or outpatient of the hospital within the three years prior to the visit. Table 2 shows relevant visit APCs for 2010.

Hospitals will continue to assign levels of visit service based on each hospital's own internal visit guidelines. CMS notes the considerable difficulties involved in developing national guidelines and reports that hospitals are billing for a stable distribution of clinic and Type A emergency visits. One commenter requested that the agency recognize codes **99363-99364** (anticoagulation management) for payment under OPPS. CMS declined, stating: "We expect that hospitals will continue to consider the hospital resources required to manage patients, including patients requiring anticoagulation management, between hospital encounters when setting their charges for the services furnished in those encounters."

Brachytherapy

CMS will make no changes to the APC assignments for the brachytherapy codes for 2010. Brachytherapy will continue to be paid under APCs **0312** (Radioelement Applications) and

0651 (Complex Interstitial Radiation Source Application). CMS noted that these APCs do not include payment for catheter placement into soft tissue (CPT code **20555**), which is paid separately through a musculoskeletal procedures APC.

CMS will also continue the use of a composite APC for low-dose-rate (LDR) prostate brachytherapy for 2010. Specifically, hospitals will receive payment for composite APC **8001** whenever needle placement (**55875**) and source application (**77778**) are reported together.

Category III code **0182T** (electronic brachytherapy) has been reassigned from New Technology APC **1519** ($1,750) to APC **0313** ($778). CMS noted that the payment for APC **1519** is about three times as much as the cost of this service as reflected in hospital claims data.

In past years the agency has been required by law to pay for brachytherapy sources on the basis of hospital charges adjusted to cost. However, this legislation expires at the end of 2009. For 2010, CMS will set payment amounts for brachytherapy sources in the same way as other services, based on 2008 claims data. Table 3 shows the separately payable brachytherapy sources for CY 2010, their APC assignments, and the national reimbursement amount (not adjusted for geographic area).

Radiation Therapy

Although CMS considered the APC Panel's recommendation that radiation therapy guidance services performed in the treatment room should be paid separately for two years, the agency decided to continue packaging radiation therapy guidance services, since data did not indicate that this decision is having a significant impact on utilization or availability to beneficiaries. Therefore, the following radiation therapy guidance services continue to be packaged for 2010:

- **77421** (stereoscopic guidance)
- **77014** (CT guidance)
- **77011** (CT guidance for stereotactic localization)
- **77417** (port films)
- **76950** (ultrasound guidance for the placement of radiation fields)
- **76965** (ultrasound guidance for interstitial radioelement application).

CMS reiterated its previous instructions that hospitals should "report all HCPCS codes that describe packaged services that were provided, unless the CPT Editorial Panel or CMS provide other guidance." The agency stated that failure to report codes for packaged services makes tracking utilization patterns and resource costs difficult. In addition to packaged guidance services, HCPCS code **0197T** [Intra-fraction localization and tracking of target or patient motion during delivery of radiation therapy (e.g., 3D positional tracking, gating, 3D surface tracking), each fraction of treatment] is also packaged in the hospital outpatient department.

Proton Beam

The APC assignments for the proton beam therapy codes remain the same for 2010, but the reimbursement is increasing. Codes **77520** and **77522** (simple proton treatment) are assigned to APC **0664** (Level I Proton Beam Radiation Therapy), which will increase from $703 to approximately $942. Codes **77523** and **77525** (intermediate and complex proton treatment) are assigned to APC **0667** (Level II Proton Beam Radiation Therapy), which will increase from $841 to $1,233.

SRS Codes

CMS made no changes to the APC assignments for the stereotactic radiosurgery (SRS) codes in 2010. Codes **77372** and **77373** continue to be nonpayable under OPPS, as hospitals are required to report SRS with HCPCS codes **G0173**, **G0251**, **G0339**, and **G0340**. CMS declined a commenter's request to revise the definitions of the SRS HCPCS Level II G-codes to distinguish between gantry-based and non-gantry-based SRS systems. CMS stated that "based on questions brought to our attention by hospitals, we have no reason to believe that hospitals are confused about the reporting of these codes."

CMS notes that HOPPS proposed rule data indicate that the 2010 APC median costs applicable to most radiation oncology services experience increases of approximately 2 percent to 15 percent compared to 2009 median costs; however, CMS reports that a small number of other lower volume radiation oncology APCs, most notably the stereotactic radiosurgery APCs, experience declines in median costs. This decline may be due to changes to the Bypass List implemented in 2009.

5-HT3 Antiemetic Drugs

Since 2005 CMS has exempted 5-HT3 antiemetic drugs from the OPPS drug packaging rules that allow separate payment for drugs only if the average cost per day exceeds the OPPS drug threshold for that year. These 5-HT3 antiemetic drugs are widely used to combat vomiting caused by cancer chemotherapy. They include dolasetron mesylate (**J1260**, **Q0180**), granisetron hydrochloride (**J1626**, **Q0166**), ondansetron hydrochloride (**J2405**, **Q0179**), and palonosetron hydrochloride (**J2469**).

For 2010, CMS no longer exempts these antiemetic drugs from the drug packaging rules. The drugs will be paid separately only if their average cost per day is greater than $65. Currently, the only 5-HT3 antiemetic that meets this criterion is palonosetron HCl (code **J2469**).

Pass-Through and Non-Pass-Through Status

Anti-cancer drugs nelarabine (**J9261**) and temsirolimus (**J9330**) lost their pass-through status effective Dec. 31, 2009. In 2010, these drugs will be paid separately only if the estimated cost per day is greater than the OPPS packaging threshold of $65. Last, CMS noted that although the average daily cost of Mesna is below the 2010 drug packaging threshold of $65, Medicare will still pay separately for it during

Table 3. Separately Payable Brachytherapy Sources for CY 2010

HCPCS Code	Definition	APC	Payment
A9527	Iodine I-125, sodium iodide solution, therapeutic, per millicurie	2632	$37.92
C1716	Brachytherapy source, non-stranded, Gold-198, per source	1716	$42.85
C1717	Brachytherapy source, non-stranded, high dose rate Iridium-192, per source	1717	$231.38
C1719	Brachytherapy source, non-stranded, non-high dose rate Iridium-192, per source	1719	$64.02
C2616	Brachytherapy source, non-stranded, Yttrium-90, per source	2616	$15,779.35
C2634	Brachytherapy source, non-stranded, high activity, Iodine-125, greater than 1.01 mCi (NIST) per source	2634	$59.80
C2635	Brachytherapy source, non-stranded, high activity Palladium-103, greater than 2.2 mCi (NIST), per source	2635	$28.59
C2636	Brachytherapy linear source, non-stranded, Palladium-103, per 1MM	2636	$19.37
C2638	Brachytherapy source, stranded, Iodine-125, per source	2638	$42.48
C2639	Brachytherapy source, non-stranded, Iodine-125, per source	2639	$36.18
C2640	Brachytherapy source, stranded, Palladium-103, per source	2640	$60.36
C2641	Brachytherapy source, non-stranded, Palladium-103, per source	2641	$57.12
C2642	Brachytherapy source, stranded, Cesium-131, per source	2642	$109.84
C2643	Brachytherapy source, non-stranded, Cesium-131, per source	2643	$66.09
C2698	Brachytherapy source, stranded, not otherwise specified, per source	2698	$42.48
C2699	Brachytherapy source, non-stranded, not otherwise specified, per source	2699	$28.59

Table 4. Hematology and Oncology Drugs with Pass-through Status for 2010

Brand Name	Code	Definition
Nplate	J2796	Injection, romiplostim, 10 mcg
Mozobil	J2562	Injection, plerixafor, 1 mg
Temodar	J9328	Injection, temozolomide, 1 mg
Fusilev	J0641	Injection, levoleucovorin calcium, 0.5 mg
Emend	J1453	Injection, fosaprepitant, 1 mg
Privigen	J1459	Injection, immune globulin (privigen), intravenous, non-lyophilized (e.g. liquid), 500 mg
HepaGam B	J1571	Injection, hepatitis B immune globulin (hepagam B), intramuscular, 0.5 ml
HepaGam B	J1573	Injection, hepatitis B immune globulin (hepagam B), intravenous, 0.5 ml
RiaSTAP	J1680	Injection, human fibrinogen concentrate, 100 mg
Hycamtin	J8705	Topotecan, oral, 0.25 mg
Treanda	J9033	Injection, bendamustine hcl, 1 mg
Firmagon	J9155	Injection, degarelix, 1 mg
Ixempra	J9207	Injection, ixabepilone, 1 mg
Vantas	J9225	Histrelin implant (vantas), 50 mg
Feraheme	Q0138	Injection, ferumoxytol, for treatment of iron deficiency anemia, 1 mg (non-esrd use)

2010, since it was separately payable in 2009, and was proposed for separate payment in 2010.

Table 4 shows the hematology and oncology drugs with pass-through status for 2010. Hospitals receive separate APC payments for drugs with pass-through status.

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