Oncology Code Update 2012

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As we welcome in a new year, there are code changes, new regulations, and more than 2,700 pages of rules and guidelines to digest and incorporate into our hospitals, physician practices, and programs. Here's a primer to help community cancer centers get started.

New Codes and Updated Descriptors

Only a few procedure code changes affect radiation and medical oncology for 2012, so updating charge tickets and fee schedules should be easy. Three new codes have been added for intraoperative radiation therapy. Codes **77424-77425** are for intraoperative treatment delivery (technical only), and code **77469** is for intraoperative treatment management (professional only):

- **77424:** Intraoperative radiation treatment delivery, X-ray, single treatment session
- **77425:** Intraoperative radiation treatment delivery, electrons, single treatment session
- **77469:** Intraoperative radiation treatment management.

The Radiation Treatment Management guidelines have been revised to reflect that although the regular treatment management codes include patient visits for three months following therapy, the intraoperative treatment management code does not include medical evaluation and management outside of the intraoperative session.

Other updates include a note added to indicate that stereoscopic guidance (code **77421**) should not be reported more than once per treatment delivery session. In addition, the special treatment procedure code (**77470**) has been revised and no longer includes intraoperative radiation.

Revision to the procedure codes for preparation of cells for transplant state that these codes should be assigned once per donor:

- **38208**: Transplant preparation of hematopoietic progenitor cells; thawing of previously frozen harvest, without washing, per donor.
- **38209**: Transplant preparation of hematopoietic progenitor cells; thawing of previously frozen harvest, with washing, per donor.

The existing procedure code for bone marrow harvesting has been revised to represent allogeneic marrow harvest, and a new code has been established for autologous marrow harvesting:

- **38230**: Bone marrow harvesting for transplantation; allogeneic.
- **38232**: Bone marrow harvesting for transplantation; autologous.

The drug administration guidelines have been revised, and now state that physicians should not report drug administration services (codes **96360-96549**) in the hospital setting with the exception of the following:

- Intralesional chemotherapy (**96405-96406**)
- Pleural chemotherapy (**96440**)
- Peritoneal chemotherapy (**96446**)
- CNS chemotherapy (**96450**)
- Subarachnoid/intraventricular chemotherapy (**96542**)
- Unlisted chemotherapy procedure (**96549**).

The guidelines have also been revised to clarify that only one "initial" service code should be reported *for a given date*. The following statement has been added to clarify this rule: "Do not report a second initial service on the same date due to an intravenous line requiring a re-start, an IV rate not being able to be reached without two lines, or for accessing a port of a multi-lumen catheter."

New guideline sections have been added to clarify the reporting of initial, sequential, and concurrent infusions, and instructions have been added to clarify reporting of multiple infusions of the same drug or substance on the same date. The guidelines provide an example of an observation patient who receives a one-hour infusion of an antibiotic every 8 hours. The hospital should report **96365** and **96366** twice for the three one-hour infusions on the same calendar date.

In addition, new examples have been added to the guidelines to clarify reporting of drug administration services that span two calendar days. If the service is continuous (e.g., hydration or infusion that continues past midnight), the code assignment is the same as for a service that is completed on a single calendar date. The date of service is the date when the infusion began. If the service is not continuous (e.g., IV push of medication before midnight and again after midnight), two initial services should be reported, one for each calendar date.

The procedure code for an additional sequential therapeutic infusion has been revised to clarify that it represents a different drug:

- **96367**: Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); additional sequential infusion of a new drug/substance, up to 1 hour (list separately in addition to code for primary procedure).

The note following code **96367** has also been revised to emphasize that this code represents the infusion of a new drug/substance after a different initial service through the same IV access. Last, the note following code **96368** (concurrent infusion) has been revised to reflect that this code should be reported only once *per date of service*, rather than once per encounter.

The 2012 *CPT Manual* also includes updated instructions relating to general code assignment. For example, the introduction has been revised to indicate that in addition to

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Table 1. New or Revised HCPCS Codes for 2012 and Deleted Codes

New or Revised Code		Deleted Code	
J1557	*Injection immune globulin (Gammaplex), IV, non-lyophilized (e.g., liquid), 500 mg*	**C9270**	*Injection immune globulin (Gammaplex), IV, non-lyophilized (e.g., liquid), 500 mg*
J0897	*Injection, denosumab, 1 mg*	**C9272**	*Injection, denosumab, 1 mg*
J9043	*Injection, cabazitaxel, 1 mg*	**C9276**	*Injection, cabazitaxel, 1 mg*
J9179	*Injection, eribulin mesylate, 0.1 mg*	**C9280**	*Injection, eribulin mesylate, 1 mg*
J0131	*Injection, acetaminophen, 10 mg*	**C9283**	*Injection, acetaminophen, 10 mg*
J9228	*Injection, ipilimumab, 1 mg*	**C9284**	*Injection, ipilimumab, 1 mg*
J7131	*Hypertonic saline solution, 1 ml*	**J7130**	*Hypertonic saline solution, 50 or 100 meq, 20 cc vial*
J7183	*Injection, Von Willebrand factor complex (human), Wilate, 1 IU VWF:RCO*	**J7184**	*Injection, Von Willebrand factor complex (human), Wilate, per 100 IU VWF:RCO*
		Q2041	*Injection, Von Willebrand factor complex (human), Wilate, per 1 IU VWF:RCO*
Q0162	*Ondansetron 1 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen*	**Q0179**	*Ondansetron hydrochloride 8 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen*
J0490	*Injection, belimumab, 10 mg*	**Q2044**	*Injection, belimumab, 10 mg*
S0119	*Ondansetron, oral, 4 mg (for circumstances falling under the Medicare statute, use HCPCS Q-code)*	**S0181**	*Ondansetron hydrochloride, oral, 4 mg (for circumstances falling under the Medicare statute, use Q0179)*

physicians and other healthcare professionals, entities such as hospitals, clinical laboratories, and home health agencies may also use CPT procedure codes. A new paragraph has been added to distinguish between a "physician or other qualified healthcare professional," who can independently perform and report healthcare services, and a "clinical staff member" who works under the supervision of a physician or professional and does not independently report services. For example, the guidelines and codes for prolonged services have been revised so that they include services performed by qualified healthcare professionals as well as physicians.

The evaluation and management services guidelines have also been revised. To be considered a new patient for physician billing purposes, the patient must not have received any professional services within the past three years from the physician or another physician of the *exact same specialty and subspecialty* from the same group practice. The guidelines previously stated "same specialty," so this is a significant change. "Professional services" are defined as face-to-face services performed by a physician and reported by a specific CPT code.

In addition to CPT procedure code changes, there have been some changes to HCPCS Level II codes as well. A new HCPCS modifier has been established to reflect the new payment policy regarding technical and facility services provided within 3 days of inpatient admission in a physician office or clinic that is wholly owned by a hospital:

- **PD**: Diagnostic or related non-diagnostic item or service provided in a wholly owned or operated entity to a patient who is admitted as an inpatient within 3 days.

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

- **C9287**: Injection, brentuximab vendotin, 1 mg.
- **J0221**: Injection, alglucosidase alfa, (Lumizyme), 10 mg.
- **J7180**: Injection, factor XIII (antihemophilic factor, human), 1 IU.
- **J8561**: Everolimus, oral, 0.25 mg.

The following drug codes have revised verbiage for calendar year 2012:

- **J0129**: Injection, abatacept, 10 mg (code may be used for Medicare when drug administered under direct supervision of a physician, not for use when drug is self-administered).
- **J0220**: Injection, alglucosidase alfa, 10 mg, not otherwise specified.
- **J1561**: Injection, immune globulin, (Gamunex/Gamunex-C/Gammaked), non-lyophilized (e.g., liquid), 500 mg.

Last, Table 1 (above) lists codes that have been deleted and replaced with new HCPCS codes for 2012. Watch for changes in the billing units as well. For example, the deleted code for eribulin mesylate was billed in 1 mg increments, but the new code will be charged in increments of 0.1 mg.

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.

Hospital Regulatory Update

CMS projects that hospitals will receive approximately $41.1 billion in 2012 for outpatient services furnished to Medicare beneficiaries under the Outpatient Prospective Payment System (OPPS). The final rule will increase payment rates under the OPPS by 1.9 percent in 2012.

As required by the Affordable Care Act, the final rule provides a payment adjustment for designated cancer hospitals, which is expected to increase payments to cancer hospitals by 11.3 percent (or approximately $71 million). In response to comments, CMS will provide the 2012 payment adjustment to cancer hospitals in the form of an aggregate payment at cost report settlement, thereby avoiding the higher copayments for beneficiaries and budget neutrality adjustment to non-cancer hospitals associated with providing the adjustment on a claims basis as was proposed.

Direct Supervision

In response to concerns that Medicare's requirement for direct physician supervision of outpatient hospital therapeutic services could hinder access for beneficiaries, specifically in rural areas, the final rule establishes an independent advisory review process to consider requests that specific outpatient services be subject to a level of supervision other than direct supervision. Under this process, CMS will seek recommendations from the Ambulatory Payment Classification (APC) Advisory Panel about appropriate supervision requirements. This panel was created to provide technical advice and recommendations to CMS about assigning items and services furnished in hospital outpatient departments to appropriate payment classifications. CMS will add two small rural PPS hospital members and two Critical Access Hospital (CAH) members to represent their interests to the Panel so that all hospitals subject to the supervision rules for payment of outpatient therapeutic services will be represented.

CMS continues to recognize supervision of hospital outpatient therapeutic services performed by midlevel providers, including physician assistants, nurse practitioners, clinical nurse specialists, certified nurse-midwives, and licensed clinical social workers. In addition, CMS will continue to accept the definition of direct supervision for all hospital outpatient services to require "immediate availability" without reference to the boundaries of a physical location. Key quotes relating to supervision in this final rule include:

We stated in the proposed rule and continue to believe that, while the statute does not explicitly mandate direct supervision, direct supervision is the most appropriate level of supervision for most hospital outpatient services that are authorized for payment as "incident to" physicians' services. We believe that the "incident to" nature of hospital outpatient therapeutic services under the law permits us to recognize specific circumstances in which general supervision is appropriate, as we have for extended duration services, and that CMS has authority to accept a recommendation by the review entity of general supervision for a given service.

However, we continue to believe that direct supervision is the most appropriate level of supervision for the majority of hospital outpatient therapeutic services and, as such, it is the default supervision standard.

As we have stated in previous rules, the supervisory responsibility is more than the mere capacity to respond to an emergency. It also includes being available to reassess the patient and potentially modify treatment as needed on a nonemergency basis. The supervisory practitioner must have, within his or her State scope of practice and hospital-granted privileges, the knowledge, skills, ability, and privileges to perform the service or procedure. Specially trained ancillary staff and technicians are the primary operators of some specialized diagnostic or therapeutic equipment, and while in such cases CMS does not expect the supervisory practitioner to operate this equipment instead of a technician, CMS does expect the practitioner that supervises provision of the service to be knowledgeable about the test and clinically appropriate to furnish the test. The supervisory responsibility includes the ability to furnish assistance and direction throughout the performance of a procedure and, as appropriate to the supervisory practitioner and the patient, to change a procedure or the course of care for a particular patient.

The supervisory practitioner should have the training and knowledge to clinically redirect the service or provide additional orders. For example, if a supervisory practitioner is only available via telemedicine, meaning telephone or internet, and is not able to be immediately physically present the supervisory practitioner would be furnishing general supervision. If a supervisory practitioner is present in a satellite office such as an off-campus PBD [provider based department] and is able to be immediately physically present but is not present in the room where the service is being furnished, he or she would be furnishing direct supervision.

For 2012 CMS will continue to regard as "extended duration services" a limited set of services with a significant monitoring component that can extend for a sizable period of time, that are not surgical, and that typically have a low risk of complication after assessment at the beginning of the services. For these specific services, there is a requirement for direct supervision at the initiation of the service, followed by general

supervision for the remainder of the service. CMS states that the point of transition from direct supervision to general supervision should be "documented prominently in progress notes or in the medical record." Extended duration services that may be transitioned to general supervision include hydration (**96360**, **96361**) and therapeutic drug administration (**96365**-**96376**, **C8957**).

Last, CMS issued instructions to contractors to not enforce the direct supervision requirement in CAHs for calendar year 2012 and is expanding this non-enforcement to include small rural hospitals with 100 or fewer beds. CMS adds, "The purpose of the nonenforcement extension is to allow these facilities time to meet the appropriate supervision standard, and to give us an opportunity to use the new APC Panel review process to consider certain changes in required supervision levels."

Drugs and Biologicals

For 2012, CMS will pay for drugs and biologicals with pass-through status at ASP (average sales price)+6 percent, equivalent to the rate these drugs and biologicals would receive in the physician office setting in 2012. CMS will pay for the acquisition and pharmacy overhead costs of separately payable drugs and biologicals without pass-through status at ASP+4 percent. CMS will also continue to include antiemetic drugs in the drug packaging rules. These drugs will be paid separately *only if* their average cost per day is greater than $75, which is the 2012 OPPS drug packaging threshold. Currently, the only 5-HT3 antiemetic that meets the criteria for separate payment is palonosetron HCl (code **J2469**).

Effective Dec. 31, 2011, the following drugs lost pass-through status:

- Cinryze (**J0598**)
- Levoleucovorin calcium (**J0641**)
- Human fibrinogen concentrate (**J1680**)
- Plerixafor (**J2562**)
- Topotecan (**J8705**)
- Ferumoxytol (**Q0138**)
- Degarelix (**J9155**)
- Temozolomide (**J9328**).

Once pass-through status expires, the drug will be paid separately only if the estimated cost per day is greater than the OPPS packaging threshold of $75.

Table 2 (below) shows the drugs that have pass-through status for 2012. Hospitals will receive separate reimbursement for these drugs.

Table 2. Hematology and Oncology Drugs with Pass-through Status for 2012

Code	Definition
C9279	Injection, ibuprofen, 100 mg
C9287	Injection, brentuximab vedotin, 1 mg
J0131	Injection, acetaminophen, 10 mg
J0490	Injection, belimumab, 10 mg
J0597	Injection, C-1 esterase inhibitor (human), Berinert, 10 units
J0638	Injection, canakinumab, 1 mg
J0897	Injection, denosumab, 1 mg
J1290	Injection, ecallantide, 1 mg
J1557	Injection, immune globulin, IV, non-lyophilized, 500 mg
J1572	Injection, immune globulin, IV, non-lyophilized, 500 mg
J7180	Injection, factor XIII (antihemophilic factor, human), 1 IU
J7183	Injection, Von Willebrand factor complex (human), Wilate 1 IU
J8562	Fludarabine phosphate, oral, 10 mg
J9043	Injection, cabazitaxel, 1 mg
J9179	Injection, eribulin mesylate, 1 mg
J9228	Injection, ipilimumab, 1 mg
J9302	Injection, ofatumumab, 10 mg
J9307	Injection, pralatrexate, 1 mg
J9315	Injection romidepsin, 1 mg
Q2043	Sipuleucel-T, minimum of 50 million autologous CD54+ cells activated with PAP-GM-CSF, including leukapheresis and all other preparatory procedures, per infusion

APCs

In 2012 there are several changes to APC assignments, and code **77338** (multi-leaf collimator IMRT treatment device) is affected again this year. Last year, CMS proposed to assign procedure code **77338** to **APC 303** (Treatment Device Construction) with a proposed payment of $198.12. CMS received numerous public comments that clarified this code is used to report all devices that are necessary for an IMRT treatment and that a typical treatment requires 3 to 9 devices. Using a hypothetical cost per unit for code **77338**, CMS determined that for 2011 this code should be assigned to **APC 310** (Level III Therapeutic Radiation Treatment Preparation), which reimburses an average allowance of $926.

However, the agency reviewed additional claims data to price this code for 2012, and determined to relocate this code to APC 305 beginning January 1, 2012. This APC has an average payment of $256, which represents a 71 percent reduction in reimbursement for this service. In response to comments, CMS stated that 965 hospitals reported a median cost of $188 for this procedure, and reminded hospitals that charges must reflect the relative resources required to furnish the service.

For 2012 CMS continues to package payment for items and services in seven categories into the payment for the primary diagnostic or therapeutic modality to which these items and services are ancillary and supportive:

1. Guidance services
2. Image processing services
3. Intraoperative services
4. Imaging supervision and interpretation
5. Diagnostic radiopharmaceuticals
6. Contrast media
7. Observation services.

CMS continues to stress that hospitals should "report all HCPCS codes that describe packaged services that were provided, unless the CPT Editorial Panel or CMS provide other guidance." CMS stated that failure to report codes for packaged services makes tracking utilization patterns and resource costs difficult.

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CODING & BILLING

Physician and Freestanding Center Regulatory Update

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The 2012 Medicare Physician Fee Schedule (MPFS) final rule specifies payment rates to physicians and other healthcare providers for more than 7,000 healthcare services and procedures, ranging from simple office visits to complex surgery. More than 1 million providers of vital health services to Medicare beneficiaries, including physicians, limited license practitioners such as podiatrists, and NPPs such as nurse practitioners and physical therapists, are paid under the MPFS. CMS projects that total payments under the MPFS in 2012 will be approximately $80 billion.

Under current law, providers will face steep across-the-board reductions in payment rates, based on the Sustainable Growth Rate (SGR) formula that was adopted in the Balanced Budget Act of 1997. Without a change in the law from Congress, Medicare payment rates to providers paid under the MPFS will be reduced by 27.4 percent for services in 2012, less than the 29.5 percent reduction that CMS had estimated in March of 2011 because Medicare cost growth has been lower than expected. (Editor's Note: On Dec. 23, Congress passed a two-month "fix" to the physician pay cut.)

Resources

The following resources were used when compiling these coding and regulatory updates:

- 2012 Medicare Physician Fee Schedule Final Rule available online at: *https://www.cms.gov/PhysicianFeeSched*. Last accessed Nov. 7, 2011.
- 2012 Medicare OPPS Final Rule available online at: *https://www.cms.gov/HospitalOutpatientPPS*. Last accessed Nov. 7, 2011.

One key reimbursement change is that CMS will substitute 103 percent of the average manufacturer price (AMP) for certain drugs that are not paid at 106 percent of the manufacturer's average sales price (ASP). This policy specifically applies to drugs that have exceeded a price substitution threshold in two consecutive quarters or three of the preceding four quarters, but only if the substituted price is lower than 106 percent of ASP.

New, Revised, & Potentially Misvalued Codes

The Affordable Care Act requires CMS to periodically review and identify potentially misvalued codes, and this final rule revises values for approximately 300 procedure codes. The final rule identifies additional categories of services that may be misvalued, including codes with low work Relative Value Units (RVUs) commonly billed in multiple units per single encounter and codes with high-volume and low-work RVUs. Specific codes included on the list for review in calendar year 2012 include:

- **77014**: CT scan for therapy guidance
- **77301**: IMRT computer plan
- **77421**: Stereoscopic X-ray guidance
- **96413**: Initial hour of IV chemotherapy
- **96365**: Initial hour of IV therapeutic drug administration
- **96367**: First hour of therapeutic drug administration, new drug.

For 2012 CMS received AMA recommendations for approximately 160 new, revised, and potentially misvalued CPT codes, including those shown in Table 3, page 17. A complete listing of misvalued work RVUs is available in Table 19 in the final rule.

PQRS and eRx Incentive Program

The Physician Quality Reporting System (PQRS) is a voluntary reporting program, first implemented in 2007, that provides an incentive payment to identified eligible professionals (EPs) who satisfactorily report data on quality measures for covered MPFS services furnished to Medicare Part B beneficiaries during a specified reporting period. The Affordable Care Act made a number of changes to PQRS, including authorizing incentive payments through 2014, and requiring a penalty beginning in 2015 for EPs who do not satisfactorily submit quality data. Physicians also have an opportunity to increase their PQRS payments by an additional 0.5 percent per year through 2014 by participating more frequently than is required in a Maintenance of Certification Program (MOC). In 2015, physicians not participating in PQRS will be subject to a 1.5 percent reduction in reimbursement and in 2016, the penalty will be 2 percent of the MPFS payments.

For 2012 successful participants in the e-Prescribing Incentive Program (eRx) will continue earn an incentive payment of 1 percent of the eligible professional's estimated total allowed charges for covered MPFS services under Medicare Part B provided during the reporting period. In addition, for years 2012 through 2014, a payment adjustment (or penalty) applies to eligible professionals who are not successful electronic prescribers and do not qualify for an eRx exemption. Beginning in 2012, there will be a 1 percent payment adjustment, which increases

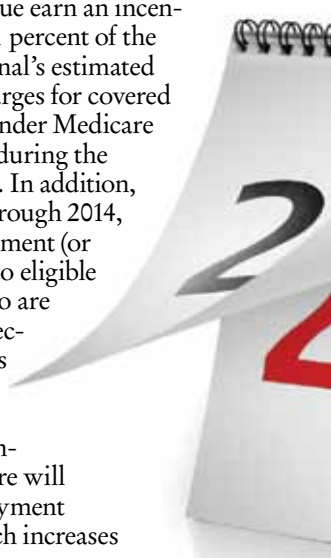

Table 3. Select List of AMA Potentially Misvalued CPT Codes

CPT Code	Short Descriptor	AMA RUC Recommended Work RVUs	CMS Decision	2012 Final Interim Work RVUs
38230	*Bone marrow harvest allogeneic*	*4.00*	*Disagree*	*3.09*
38232	*Bone marrow harvest autologous*	*3.50*	*Disagree*	*3.09*
77435	*SBRT management*	*11.87*	*Agree*	*11.87*
77469	*IO radiation treatment management*	*5.75*	*Agree*	*5.75*

Table 4. Combined 2012 Total Allowed Charge Impact by Specialty as Listed by CMS*

Specialty	Impact of Work & MP RVU Changes	PE RVU Changes FULL	PE RVU Changes TRAN	Combined Impact FULL	Combined Impact TRAN
Hematology/Oncology	*0%*	*-1%*	*0%*	*-1%*	*0%*
Radiation Oncology	*0%*	*-10%*	*-6%*	*-10%*	*-6%*
Radiation Therapy Centers	*0%*	*-11%*	*-6%*	*-11%*	*-6%*

*These percentages do *not* include the potential Cost Factor reduction.

to 1.5 percent in 2013 and 2 percent in calendar year 2014.

The combined 2012 total allowed charge impact by specialty can be found in Table 4, above.

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Definitions for Tables 3 and 4 (above)

1. **Impact of Work and Malpractice (MP) RVU Changes:** This column shows the estimated 2012 impact on total allowed charges of the changes in the work and malpractice RVUs, including the impact of changes due to potentially misvalued codes. These impacts are primarily due to the multiple procedure payment reduction (MPPR) for the professional component of advanced imaging services.

2. **Impact of PE RVU Changes - Full:** This column shows the estimated 2012 impact on total allowed charges of the changes in the practice expense (PE) RVUs if there were no remaining transition to the full use of the Physician Practice Information Survey (PPIS) data.

3. **Impact of PE RVU Changes - Tran:** This column shows the estimated 2012 impact on total allowed charges of the changes in the PE RVUs under the third year of the 4-year transition to the full use of the PPIS data. This column also includes the impact of the MPPR policy and the impact of changes due to potentially misvalued codes.

4. **Combined Impact - Full:** This column shows the estimated 2012 combined impact on total allowed charges of all the changes in the previous columns if there were no remaining transition to the new PE RVUs using the PPIS data.

5. **Combined Impact - Tran:** This column shows the estimated 2012 combined impact on total allowed charges of all the changes in the previous columns under the third year of the 4-year transition to the new PE RVUs using the PPIS data. These are the combined impacts for 2012.