Oncology Reimbursement Update 2014

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Prior to releasing its final rules on Nov. 27, 2013, the Centers for Medicare & Medicaid Services (CMS) published updated beneficiary cost-sharing and premium payments for those enrolled in original Medicare during calendar year (CY) 2014 in Transmittal R82GI, dated Nov. 15, 2013. The inpatient hospital deductible will increase to $1,216 for the first 60 days, and daily coinsurance for days 61 to 90 will increase to $304. The coinsurance amount for days 21 through 100 in a skilled nursing facility will increase to $152 per day. For Medicare Part B services, the annual deductible remains the same at $147.00.[1]

New & Revised Codes

Each year there are new codes, revised codes, and updates to coding guidelines. Effective Jan. 1, 2014, there has been a rewrite of the code definitions for radiation oncology simulation services. The codes are now defined as follows:

- **77280:** Therapeutic radiology simulation-aided field setting; simple simulation of a single treatment area.
- **77285:** Therapeutic radiology simulation-aided field setting; intermediate simulation of two separate treatment areas.
- **77290:** Therapeutic radiology simulation-aided field setting; complex. Three or more treatment areas, or any number of treatment areas if any of the following are involved: particle, rotation, or arc therapy, complex blocking, custom shielding blocks, brachytherapy simulation, hyperthermia probe verification, or any use of contrast materials.

There is a new add-on code for motion management during the radiation simulation process:

- **+77293:** Respiratory motion management simulation. (List separately in addition to the code for the primary procedure).

This code describes the physician work and resources involved in acquiring a respiratory correlated 4D simulation study for conformal planning. This code will only be reported on the same service date as codes **77295** (3D radiation planning) or **77301** (IMRT treatment planning). An "add-on" code represents a service performed in addition to the primary procedure and applies only to procedures or services performed by the same physician. Add-on codes are always performed in addition to the primary procedure and are never reported as a stand-alone code.

The code for 3D simulation was redefined and relocated to a different section of the *CPT Manual*:

- **77295:** Three-dimensional radiotherapy plan, including dose-volume histograms.

Telephone and/or Internet Consultations

There is also a new set of codes to report inter-professional telephone and/or Internet consultations. An inter-professional telephone and/or Internet consultation is an assessment and management service during which a patient's treating physician or other qualified healthcare professional requests an opinion and/or treatment advice of a physician with specialty expertise to assist in the diagnosis and/or management of the patient's condition without the need for a face-to-face patient encounter with the consultant. The consulting physician reports one of the following codes:

- **99446:** Inter-professional telephone and/or Internet assessment and management service provided by a consultative physician, including a verbal and written report to the patient's treating and/or requesting physician or other qualified healthcare professional; 5-10 minutes of medical consultative discussion and review.
- **99447:** 11-20 minutes of medical consultative discussion and review.
- **99448:** 21-30 minutes of medical consultative discussion and review.
- **99449:** 31 minutes or more of medical consultative discussion and review.

According to the code definitions included in the 2014 *CPT Manual:*

These services are typically provided in complex and/or urgent situations where a timely face-to-face service with the consultant may not be feasible.

The patient may be either a new patient to the consultant or an established patient with a new problem or exacerbation of an existing problem. The consultant must not have seen the patient in a face-to-face encounter during the prior 14 days. In addition, these codes are not reported if the telephone/Internet consultation leads to an immediate transfer of care or other face-to-face service within the next 14 days or next available appointment. Last, this service should not

be reported more than once within a 7-day interval.

Review of pertinent medical records, laboratory studies, imaging studies, medication profile, or pathology specimens may be required and transmitted electronically by fax or by mail immediately before the telephone/Internet consultation or following the service. The review of this data is included in the telephone/Internet consultation service and not reported separately.

The majority of the service time reported (greater than 50%) must be devoted to the medical consultative verbal/Internet discussion. If more than one telephone/Internet contact is required to complete the consultation request, the entirety of the service and the cumulative discussion should be reported with a single code.

The written or verbal request for advice should be documented in the patient's medical record, including the reason for the request and a written report from the consulting physician to the treating physician. In addition, the requesting physician must notify the patient, since there will be deductible and/or coinsurance due for the service billed by the consultant.

When the sole purpose of the telephone/Internet communication is to arrange a transfer of care or other face-to-face service, these codes are not reported. In addition, telephone/Internet consultations of less than 5 minutes should not be reported.

Clarification in Push Codes

The 2014 *CPT Manual* clarified the correct use of push codes when medication is administered more than once during a hospital stay. According to the updated guidelines:

However, if instead of a continuous infusion, a medication was given by intravenous push at 10 PM and 2 AM, as the service was not continuous, the two administrations would be reported as an initial service (96374) and sequential (96376) as: (1) no other infusion services were performed; and (2) the push of the same drug was performed more than 30 minutes beyond the initial administration.

Last, the American Medical Association (AMA) added cautionary verbiage in the introduction to Appendix C, Clinical Examples. This appendix includes samples of services performed that meet the definition of various patient visit codes. The new verbiage includes:

Therefore, these examples are not appropriately used for any review of correct coding or estimating physician or other qualified health care professional work. These clinical examples do not encompass the entire scope of medical practice.

A particular patient encounter, depending on the specific circumstances, must be judged by the services provided by the physician or other qualified health care professional for that particular patient.

In addition to new and revised procedure coding instructions, there have been some significant updates to HCPCS Level II codes. Table 1 (below) shows the new codes established for drugs effective Jan. 1, 2014. Other HCPCS codes were deleted and replaced with new HCPCS Level II codes (see Table 2, page 14).

Oral Anti-Emetics

A new code was established for oral chlorpromazine hydrochloride, oral 5 mg, and the codes for the 10 mg and 25 mg doses were deleted.

- **New Code Q0161:** Chlorpromazine hydrochloride, 5 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.
- **Deleted Code Q0171:** Chlorpromazine

Table 1. New Oral Anti-Emetic HCPCS Level II Codes

CODE	DEFINITION
C9132	Prothrombin complex concentrate (human), KCentra, per i.u. of factor IX activity
C9133	Factor IX (antihemophilic factor, recombinant), Rixubis, per i.u.
C9441	Injection, ferric carboxymaltose, 1 mg
C9497	Loxapine, inhalation powder, 10 mg
J0401	Injection, aripiprazole, extended release, 1 mg
J1602	Injection, golimumab, 1 mg, for intravenous use
J9371	Injection, vincristine sulfate liposome, 1 mg

Table 2. New HCPCS Level II Codes That Replaced Deleted Codes

2014 NEW CODE		2013 DELETED CODE	
J1556	Injection, immune globulin (bivigam), 500 mg	**C9130**	Injection, immune globulin (bivigam), 500 mg
J9354	Injection, ado-trastuzumab emtansine, 1 mg	**C9131**	Injection, ado-trastuzumab emtansine, 1 mg
J9306	Injection, pertuzumab, 1 mg	**C9292**	Injection, pertuzumab, 10 mg
J3060	Injection, taliglucerase alfa, 10 units	**C9294**	Injection, taliglucerase alfa, 10 units
J9047	Injection, carfilzomib, 1 mg	**C9295**	Injection, carfilzomib, 1 mg
J9400	Injection, ziv-aflibercept, 1 mg	**C9296**	Injection, ziv-aflibercept, 1 mg
J9262	Injection, omacetaxine mepesuccinate, 0.01 mg	**C9297**	Injection, omacetaxine mepesuccinate, 0.01 mg
Q2050	Injection, doxorubicin hydrochloride, liposomal, not otherwise specified, 10 mg	**J9002**	Injection, doxorubicin hydrochloride, liposomal, doxil, 10 mg
Q3027	Injection, interferon beta-1a, 1 mcg for intramuscular use	**Q3025**	Injection, interferon beta-1a, 11 mcg for intramuscular use
Q3028	Injection, interferon beta-1a, 1 mcg for subcutaneous use	**Q3026**	Injection, interferon beta-1a, 11 mcg for subcutaneous use
J0717	Injection, certolizumab pegol, 1 mg (code may be used for Medicare when drug administered under the direct supervision of a physician, not for use when drug is self-administered)	**J0718**	Injection, certolizumab pegol, 1 mg

hydrochloride, 10 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.

- **Deleted Code Q0172:** Chlorpromazine hydrochloride, 25 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.

The following oral anti-emetic HCPCS codes were deleted effective Jan. 1, 2014, without the creation of corresponding new codes:

- **Q0165:** Prochlorperazine maleate, 10 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.
- **Q0168:** Dronabinol, 5 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.
- **Q0170:** Promethazine hydrochloride, 25 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.
- **Q0176:** Perphenazine, 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.
- **Q0178:** Hydroxyzine pamoate, 50 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.

With the FDA approval in 2013 of Astragraf XL, a sustained-release form of the immunosuppressive drug tacrolimus, the description of the tacrolimus code (**J7507**) was revised and new code **J7508** was created for CY 2014 to distinguish between immediate and sustained release forms of the drug. The new codes are now:

- **J7507:** Tacrolimus, immediate release, oral, 1 mg.
- **J7508:** Tacrolimus, extended release, oral, 0.1 mg.

The three existing codes for the osteoporosis drug zoledronic acid (**J3487**, Zometa; **J3488**, Reclast; and **Q2051**, not otherwise specified), which distinguished between different formulations or brand names, have been deleted and replaced with a single code: **J3489**.

Two existing codes for filgrastim G-CSF (Neupogen) were deleted (**J1440** and **J1441**), and two new codes were established for filgrastim G-CSF and TBO-filgrastim (Granix). The two new codes are:

- **J1442:** Injection, filgrastim (G-CSF), 1 microgram. (When updating code information, note the dosage change.)
- **J1446:** Injection, TBO-filgrastim, 5 micrograms.

In addition to code changes, Table 1 (page 13) shows the new HCPCS Level II oral anti-emetic drug codes that became effective Jan. 1, 2014.

Electrical Stimulation for Cancer Treatment

Two new supply codes were created for devices used in electrical stimulation for cancer treatment:

- **A4555:** Electrode/transducer for use with electrical stimulation device used for cancer treatment, replacement only.
- **E0766:** Electrical stimulation device used for cancer treatment includes all accessories, any type.

IVIG Demonstration Project

A code was created for supplies used in the Medicare IVIG demonstration project: **Q2052**, services, supplies and accessories used in the home under the Medicare intravenous immune globulin (IVIG) demonstration. OI

References

1. CMS. Update to Medicare Deductible, Coinsurance and Premium Rates for 2014. Available online at: *www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2013-Transmittals-Items/R82GI.html*. Last accessed Dec. 2, 2013.
2. CMS. Transmittal 310: Requirements for Including an 8-Digit Clinical Trial Number on Claims. Available online at: *www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R310OTN.pdf*. Last accessed Dec. 2, 2013.
3. CMS. Transmittal R2805CP: Mandatory Reporting of an 8-Digit Clinical Trial Number on Claims. Available online at: *www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2013-Transmittals-Items/R2805CP.html*. Last accessed Dec. 2, 2013.

Mandatory Clinical Trial Number

While not published as part of a final rule, CMS released information in October 2013 that states the clinical trial number must be included on claims for trial patients beginning Jan. 1, 2014.

Effective April 1, 2008, CMS allowed the *voluntary* submission of the 8-digit clinical trial number on both the hospital and physician claim forms. The number that CMS requested is the number assigned by the National Library of Medicine (NLM) Clinical Trials Data Bank when a sponsor or investigator registers a new study. CMS was using this number to identify all items and services provided to beneficiaries during their participation in a clinical trial.[2] This identifier also permitted CMS to meet the recommendations from the White House Executive Memorandum to increase Medicare participation in clinical trials by tracking Medicare payments for trial services, using the information gathered to make informed coverage decisions and ensuring that research focuses on issues that are important to the Medicare population.

Effective Jan. 1, 2014, CMS no longer considered the inclusion of the clinical trial number to be voluntary; instead, healthcare providers are required to report the 8-digit trial number on all claims during the time period the beneficiary participates in the trial. Transmittal 2805, dated Oct. 30, 2013, includes claim submission details and states:[3]

Medicare Part B clinical trial/registry/study claims with dates of service on and after January 1, 2014, not containing an 8-digit clinical trial number will be returned as unprocessable to the provider for inclusion of the trial number.

This Transmittal includes the following instruction:

The clinical trial number that the Centers for Medicare & Medicaid Services (CMS) is making mandatory is the same number that has been reported voluntarily since the implementation of CR5790, TR310, dated January 18, 2008, the number assigned by the National Library of Medicine (NLM) ClinicalTrials.gov website when a new study appears in the NLM Clinical Trials data base.

All hospitals, freestanding cancer centers, and physicians should keep in mind that once the clinical trial number has been captured by the CMS Common Working File (CWF), any subsequent claim for that patient without the mandatory NLM study number could be rejected. As a result, it is essential that internal tracking of clinical trial patients, manually or electronically, be maintained to ensure that all services, including but not limited to, oncology services, imaging, laboratory, professional charges, surgery, and other related diagnostic and/or therapeutic procedures include the appropriate clinical trial number to prevent claim rejection. In addition, all physicians and facilities providing any part of the trial patient's care must coordinate to appropriately report investigational and routine services performed as part of the trial protocol.