INTERPRETATIONS OF CPT CODING CREATE CONFUSION AMONG ONCOLOGISTS

by Martin E. Neltner

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In response to the article, "Medicare Demands Supervision Fee Refunds In Indiana," (see Oncology Issues, *Winter 1989, page five) Martin Neltner, a consultant in the area of oncology practice management, provides some needed clarification about proper billing and coding for medical oncologists' professional services.*

Medicare auditors in Indiana have a misunderstanding of how a medical oncologist reports professional services under the physicians' current procedural terminology (CPT) coding system. CPT codes 96500 through 96549 are independent of the medical oncologist's "patient visit;" they represent first the professional service of the medical oncologist. How else could this service be rendered if it were not for the medical oncologist's expertise and knowledge of the treatment of neoplastic disease?

Medical oncologists have always had their own unique professional fee, and they have been billing this fee for years. Even the coding system prior to CPT recognized a professional fee separate from the office visit. However, there have been, and probably will continue to be, some problems reporting these services, because of confusion created by the current descriptions in the physicians' *Current Procedural Terminology* Book, Fourth Edition (CPT-4), and by the fact that many Medicare carriers have not required the use of modifiers.

The ruling the auditors in Indiana cited refers to the phrase, "incident to," and has been misapplied by the carrier. The ruling states that physicians who render a service incident to the service (i.e., supervision, etc.) may bill for a professional fee as long as they are present in the "office." Office is defined by the Health Care Financing Administration (HCFA) as any location in which the physician renders professional services. This may include the outpatient department of a hospital, a nursing home, the patient's home, or the physician's private office. However, the "incident to" rule does not apply to inhospital services; therefore, medical oncologists do not need to be concerned about being present while chemotherapy is being administered on an inpatient or 24-hour basis. With regard to the reporting of professional services, the regulations say nothing about renting space or the nurse having to be employed by the oncologist. However, in every audit conducted by Medicare, there has been no consistency in how the auditors applied this rule to different situations. The CPT code adopted by HCFA is, first, a physician professional fee and, second, a technical fee when the physician pays for the overhead (i.e., rent, labor, equipment, etc.) Exhibits one and two illustrate the components of the office visit and chemotherapy management, and thoroughly explain the

> ***Current descriptions in CPT-4 have caused continuing problems in the billing of professional services***

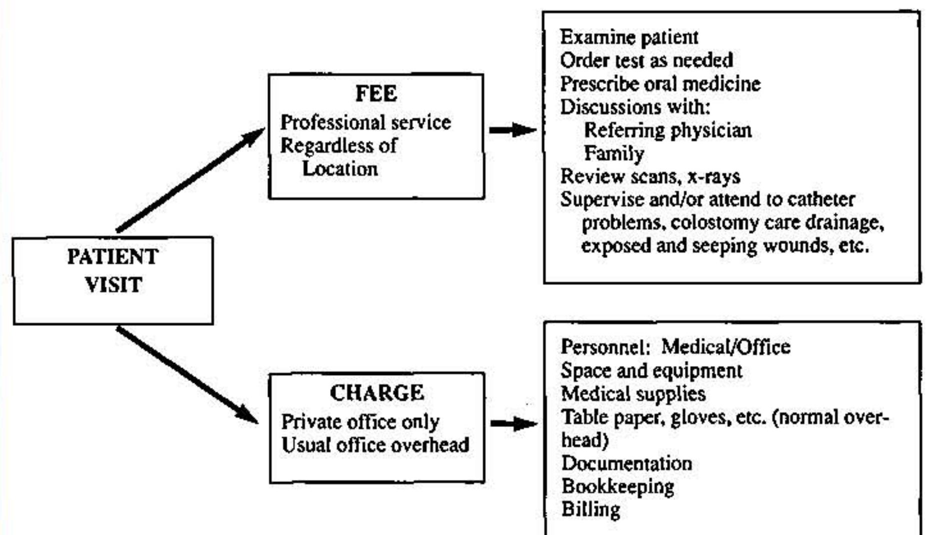
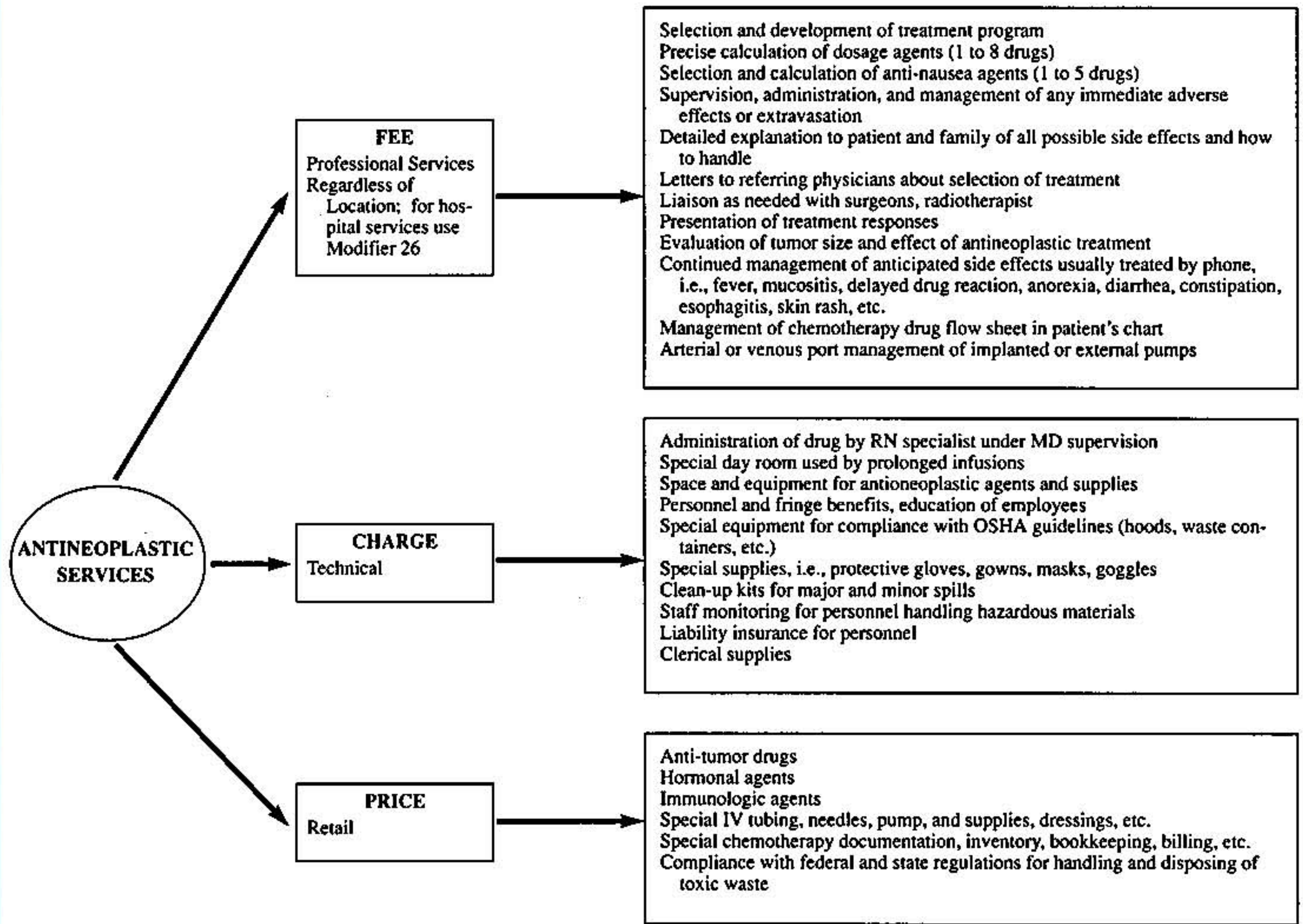


EXHIBIT 2

ANTINEOPLASTIC SERVICES



services of a medical oncologist.

The communication problems and resultant misunderstandings in Indiana were the result of aggressive auditors who did not consider, or inquire about, how the oncologist professional fee relates to CPT-4. The auditors' primary complaint was that "the documentation they reviewed did not clearly communicate what the oncologist does." It is understandable that an auditor who is not familiar with medical oncology management might confuse CPT codes 96500 through 96549 with technical services. Certainly, descriptions such as "independent of office visit" and "injections" imply technical services. However, that was not the intent of the author of the CPT coding system.

In an effort to counter the damage Medicare auditors have caused in the state of Indiana, medical oncologists have organized an Indiana Medical Oncology Society and are meeting with the medical director of Medicare to try and resolve coding interpretations. In addition, the Clinical Practice Committee of the American Society of Clinical Oncology (ASCO) has presented recommendations to the American Medical Association's CPT Advisory Committee that would help to clarify that professional services are separate from patient visits. Hopefully, adequate changes will be reported in the 1990 CPT update. In the meantime, medical oncologists should continue to bill for their professional fees. However, they should carefully document the visit and oncology management service to avoid future misunderstandings with Medicare auditors. ■

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