Overview of Billing & Coding for Cancer Drugs

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- All Medicare information is derived from published rules; however, interpretations may differ and typographical errors may be evidenced. It is mandatory that coding and billing is based on information derived from each practice's or clinic's actual documentation.
- This is not legal or payment advice.
- This content is abbreviated for Medical Oncology. It does not substitute for a thorough review of code books, regulations, and Carrier guidance.
- This information is valid for the date of presentation only.
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Agenda

- Introduction to Reimbursement Terms
- Medicare Alphabet Soup
- Physician Revenue Cycle
- Physician Reimbursement and Coding
- Hospital Revenue and Payment
- Hospital Reimbursement and Coding
  - Compared With Physician Reimbursement and Coding
- Drug Coding and Reimbursement
  - Both Settings
- Questions?

Reimbursement

- Definition
  - Healthcare providers are paid by insurance or government payers through a system of reimbursement. They provide medical services to a patient and then file for reimbursement for those services with the insurance company or government agency. It's not the patient who is paying out of pocket and getting reimbursed, it is the doctor who is providing a service and then awaiting reimbursement

Reimbursement is based upon the:

- type of item or service being billed
- third party payer
- healthcare setting or provider
- coding system used
- data set utilized

Risk Avoidance

- Insurers develop and implement schemes to mitigate their financial risk including
  - Prospective payment
  - Prior authorization
  - Code Edits (“MUEs”)
  - Medical Policies
  - Pathways
  - Risk Pooling
  - Patient Payments
  - Retrospective Review

Prospective Payment

- MS-DRGs (Current Medicare Inpatient Payment)
  - One payment for all services per discharge for Medicare
  - Based on coding after discharge
- Episodes of Care
  - One payment for a major tumor type for a period of months
  - Oncology demonstration by United Health yielded about 34% savings
  - Ongoing Oncology Care Model from the Centers for Medicare & Medicaid Innovation (“CMMI”)
- Per Diems
  - A single payment for a day of inpatient care
- Capitation (More Later)

Capitation

- Capitation is a fixed amount of money per patient per unit of time paid in advance to the physician for the delivery of health care services. The actual amount of money paid is determined by the ranges of services that are provided, the number of patients involved, and the period of time during which the services are provided. Capitation rates are developed using local costs and average utilization of services and therefore can vary from one region of the country to another.

Gatekeeping

- Prior authorization—Getting required permission to treat with a certain procedure, services, or item
- Referral---Getting permission from the primary care physician to treat
- Step Therapy---Try one therapy before another
- Utilization Review—Review treatment or therapy before continuing

Medical Policies

- Medical policies dictate whether an item or services will be (or how it will be) paid by the plan. With drugs this can mean
  - Covered indications for the drug
  - Population that can take the drug
  - Billing parameters for the drug
- Medical policies can restrict access to your drug or change the billing of it.
- Many payers, including Medicare and Medicare Advantage, call their policies Local Coverage Decisions (“LCDs). The reason they are called this is to reflect the clinical practices in a specific area.

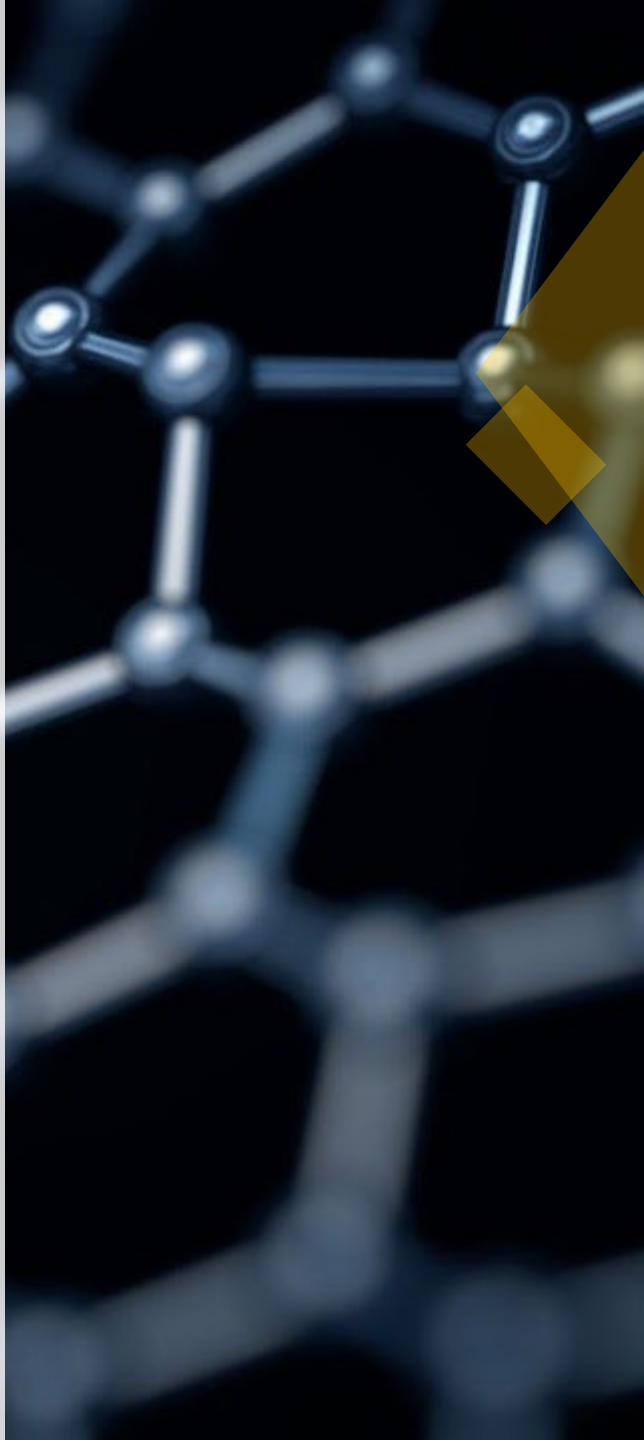
Coverage and Payment Are Fundamental Questions of Reimbursement

Coverage determines if a benefit exists for a specific service or product

- Does coverage exist for the class of service (e.g., plastic surgery)?
- Does coverage exist for a specific medical technology within the class of service (e.g., implanted osmotic pump for prostate cancer)?

Payment is the amount reimbursed for a covered service or product (minus the patient portion of what is allowed)

- Does appropriate coding exist to link services to a level of payment (e.g, evaluation and management services billed by physicians)?
- Is the level of payment adequate for services rendered (e.g., chemotherapy infusion services)?



Pathways

- Entities establish ‘ideal’ drug regimens for both quality and cost
- These entities can include:
  - Insurance companies (AIM)
  - Teaching hospitals (VIA)
  - Drug distributors (P4/Cardinal Healthcare)
  - Industry organizations (NCCN)

Rejections and Denials

- After the claim is billed, a payer may decide not to pay for it based on the restrictions of the policy, plan, or intermediary
  - Denials, if they are based on plan structure (e.g. limits on benefits, deductibles), may not be appealed
  - If denials are based on the patient's condition and medical interpretation of the need for item or service, they may be appealed

Audits

- Audits are reviews of a sample of records, usually months or years after claims have been paid. Reviews may be based on
  - Unusual billing patterns
  - An area of focused review by the payer
  - Possible civil or criminal problems
  - Random (rare)

Medicare Alphabet Soup

What You Need To Know

ABN

CMD

LCD

NCD

Incident to

ABN

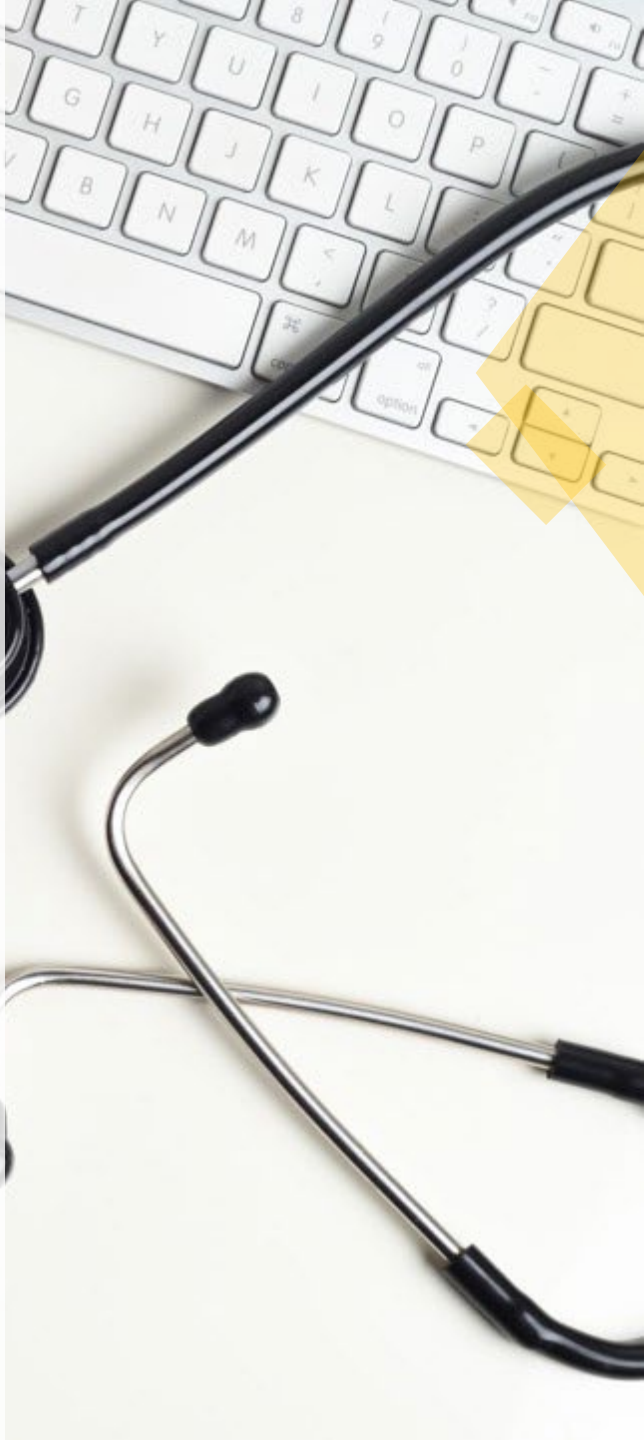
- Advance Beneficiary Notice
  - The ABN allows the beneficiary to make an informed decision about whether to get the item or service that may not be covered and accept financial responsibility if Medicare does not pay. It also allows drug companies to pay for denied claims if the patient cannot afford to pay the provider.
  - If the beneficiary does not get written notice when it is required, he or she may not be held financially liable if Medicare denies payment, and the provider may be financially liable if Medicare does not pay. The ABN is used for Medicare Part B (outpatient) and Part A (limited to hospice, Home Health Agencies, and Religious Nonmedical Health Care Institutions only) items and services.

MACs

- These are contractors (Medicare Administrative Contractors) that administer Medicare activities within a certain area.
- These change periodically so it is important to be sure to keep up to date on the identity of the MACs.
  - https://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/Who-are-the-MACs

CMD

- This is a Contractor Medical Director (“CMD”). This person is responsible for medical policy for a specific Medicare Contractor and can be a way to change policy, when desirable
- To contact yours, go to http://www.cms.gov/medicare-coverage-database/indexes/contacts-alphabetical-index.aspx?bc=AgAAAAAAAAAAAA%3d%3d&



LCDs

- Each Medicare contractor has the discretion to establish which services are considered reasonable and necessary, and therefore paid as a Medicare benefit—these are called Local Coverage Determinations (“LCDs”). When finalized, these are the rules and regulations by which physicians are held accountable in an audit
- There are three stages of LCDs…

3 Stages of LCDs

- 1. **Draft LCDs.** Once developed, typically in conjunction with the carrier advisory committee members, the Medicare contractor must provide a comment period and a notice period with the establishment of:
  - A new LCD;
  - The revision of an existing LCD that is more restrictive; and
  - The revision of an existing LCD that involves a substantive correction.
- The draft, posted on the payer website, allows 45 days for comment. During this period, Medicare solicits comments and recommendations from a wide range of individuals and organizations. After comments are received and any revisions made, the final LCD must be posted with a minimum notice period of 45 calendar days.

  2. **Final (Active) LCDs.** Each final LCD has an effective date and a distinct coverage area. Typical LCDs include a description of each covered service, documentation requirements and information regarding the ICD-9 codes that do or do not support medical necessity.

  To find the LCDs specific to your state, visit your local Medicare Part B website. You can also view the policies from each state by visiting the Medicare coverage database.

  3. **Retired LCDs.** Medicare contractors are required to archive retired LCDs. They can be useful as a guide.

NCDs

- National coverage determinations (NCDs) are made through an evidence-based process, with opportunities for public participation. In some cases, CMS' own research is supplemented by an outside technology assessment and/or consultation with the Medicare Evidence Development & Coverage Advisory Committee (MEDCAC). In the absence of a national coverage policy, an item or service may be covered at the discretion of the Medicare contractors based on a local coverage determination (LCD)

NCDs

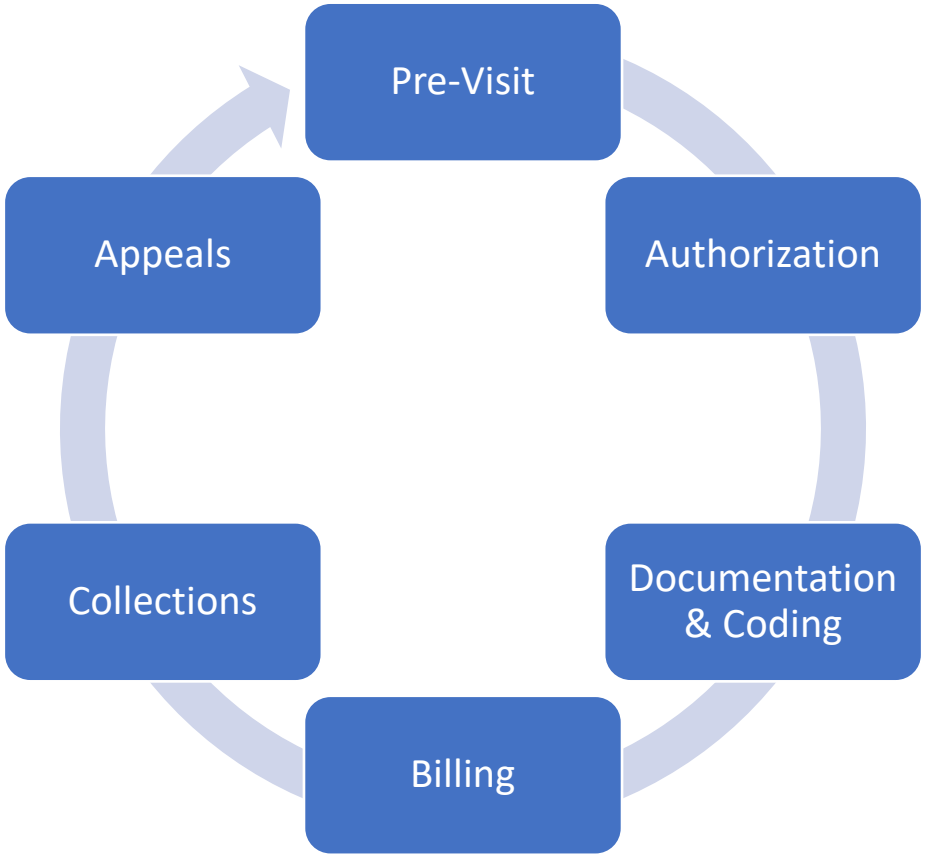
- Examples of NCDs in cancer include:
  - Policy on ESAs
  - Policies on lab tests
  - Policy on aprepitant
- See more at http://www.cms.gov/medicare-coverage-database/indexes/ncd-alphabetical-index.aspx?bc=BAAAAAAAAAAA

“Incident To”

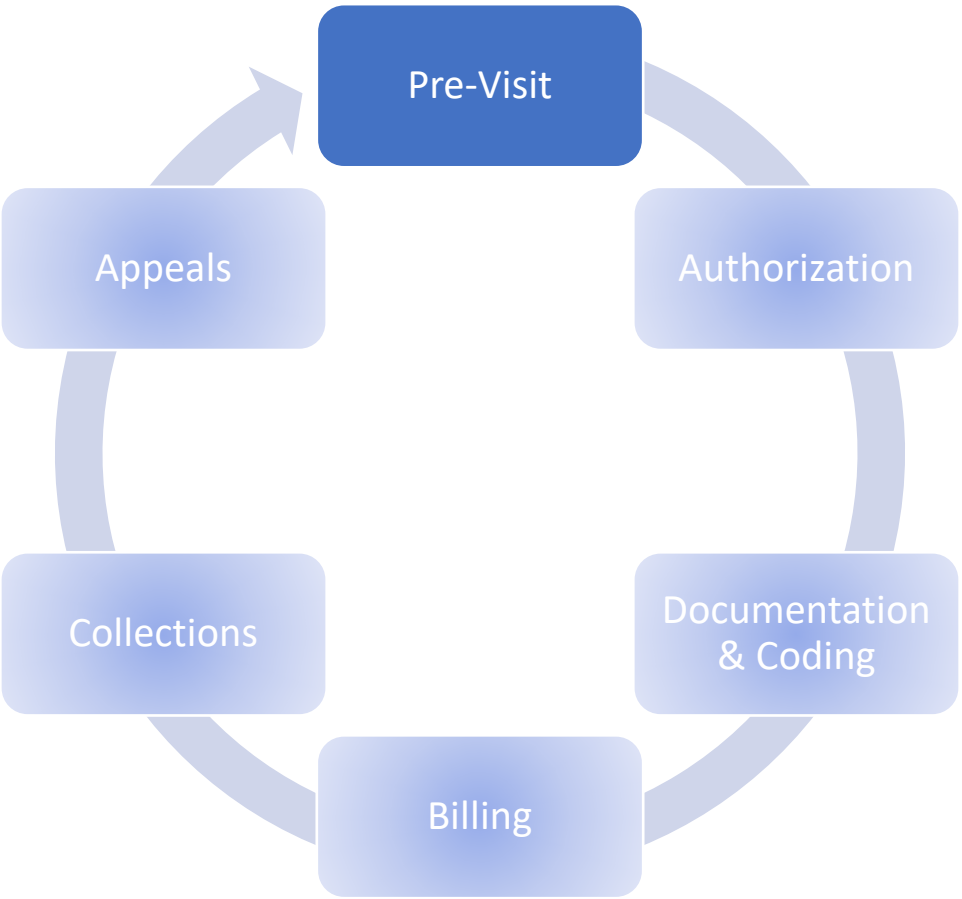
- Incident to a physician’s professional services means that the services or supplies are furnished as an integral, although incidental, part of the physician’s personal professional services in the course of diagnosis or treatment of an injury or illness.
- It means that for a drug to be covered under Part B Medicare:
  - The drug may not be self-administered
  - It must be on the Provider Bill
  - It must represent an expense to the Provider
  - The physician must be in the office suite during treatment
- When a physician supervises auxiliary personnel to assist him/her in rendering services to patients and includes the charges for their services in his/her own bills, the services of such personnel are considered incident to the physician’s service if there is a physician’s service rendered to which the services of such personnel are an incidental part and there is direct supervision by the physician.

Revenue Cycle in the Oncology Office

The Cycle of Getting Paid



Issues Can Arise Even Before the First Visit



One must collect a variety of information to ensure payment. Missing any one of the following can result in nonpayment:

- Demographic and insurance information
- List accurate guarantor in the record
- Ensure physician dictated clinical information necessary for prior authorization
- Verify insurance and benefits by telephone (not online) – *See next slide*
- Obtain authorizations and/or referrals for known services
- Establish solid financial terms with the patient in the conditions of treatment*

*Conditions of treatment gives permission to release information in order to get paid; requires patients to get referrals that are necessary; requires patients to notify at the time of service change of employer; requires patients to notify at the time of service change of insurance; requires patients to supply income and asset information if they become uninsured or if they are denied coverage of their therapy; allows you to access credit cards; and allows you to perform a credit check for high balances.

Insurance Verification

Necessary Elements of an Insurance Verification

- ✓ Patient has purported insurance/it is primary with effective date (and insurance address for bill)
- ✓ Plan type: HMO/PPO/other
- ✓ Deductibles impacting care delivered in the office, e.g. IV drugs, radiology, labs, chemotherapy administration
- ✓ Episodic patient cost sharing for in-office-delivered care, e.g. flat co-pays for Rx; coinsurance payments, amount
- ✓ Lifetime, annual or episode out-of-pocket (OOP) max
- ✓ Catastrophic coverage (yes/no)
- ✓ Benefit caps: lifetime or other
- ✓ If possible, patient's current status regarding deductibles and OOP maximums; current progress toward caps
- ✓ Insurer requirements: Prior authorization; certification; notification; case management, step therapy
- ✓ Specialty pharmacy preference for patient costs, pharmacy billing
- ✓ If it is a new drug, access miscellaneous guidelines at this point, if you can

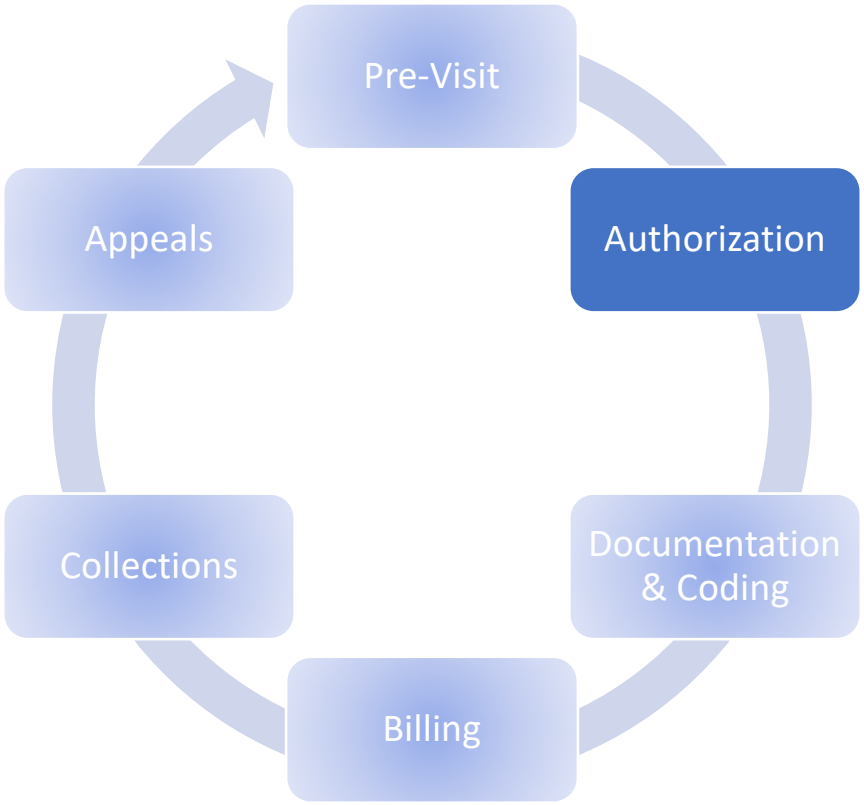
Consequences of a Bad Insurance Verification

- Wrong insurance billed
- Poor coordination of benefits
- Patient gets drug while uninsured
- Benefits are exhausted
- PCP referral not obtained
- Step therapy not given
- Patient responsibility not estimated and not collected
- Appropriate programs and Foundations not accessed

Facilitating this process to speed time to treatment

- Provide education to support accurate insurance verification
- Collect explanations of benefit from the various payers across the country to have available for offices seeking specific payer guidelines

Obtaining a Prior Authorization (PA)



Once the insurance has been verified, PA is typically necessary (or at least a good idea). Components to a good PA:

- Patient description: age, sex, performance status (if applicable)
- Reason for the drug (ICD-10's and verbal description, stage, histology)
- History of present illness in chronological order
- Failed/ other therapies (if applicable)
- Proposed course of therapy: dosing, regimen, time frame
- Supporting literature and/or package insert, if new therapy or new indication

Shortening the PA timeframe

- If payers have forms, have forms available
- If using an EMR, incorporate PA guidelines into an EMR template or dictation; check for completion; and download to CD/DVD or fax
- It is also really helpful to have a medical contact within the insurance company

*California law requires that if a health plan or its contacting medical group/IPA authorizes a health care service and the physician provides the service in good faith and pursuant to the authorization, the plan/IPA must pay the claim. Plans are prohibited from rescinding or modifying an authorization for any reason, even if the plan made a mistake in providing the authorization. (Health & Safety Code § 1371.8; 28 C.C.R. § 1300.71(a)(8)(T); Insurance Code § 796.04.) – California Medical Association

Chart Documentation and Coding

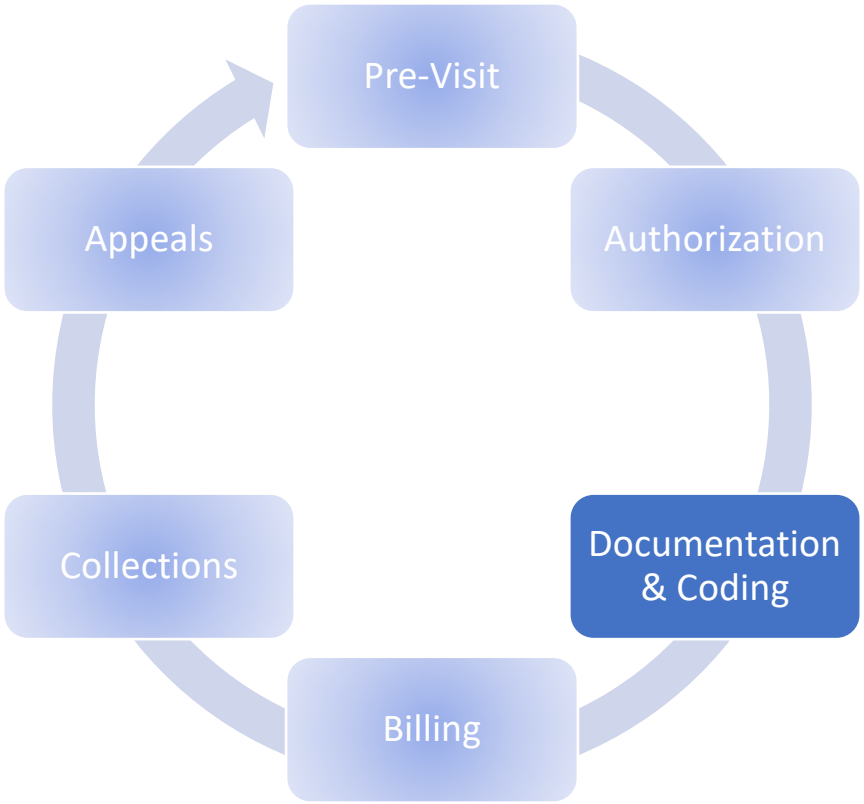


Chart Documentation

- An order for the drug must be signed by the ordering provider or else if Medicare sees the chart, it will be irrevocably denied
- Failed other therapies, if that is part of the new drug label
- Detailed information that the patient conforms to the label criteria and is qualified to receive this therapy now
- Up and down times that correspond with labeling

Coding

- Do you know what this drug is given for? Is that documented in the chart? Do you have the correct diagnosis code?
- Are there payer billing guidelines established for which unlisted code you should use? J9999? J3590? J3490? C-codes?
- Does the payer require NDC code? Do you have it?
- What drug units does the payers want?
- What all goes in place formerly known as Box 19 on the CMS-1500 claim?

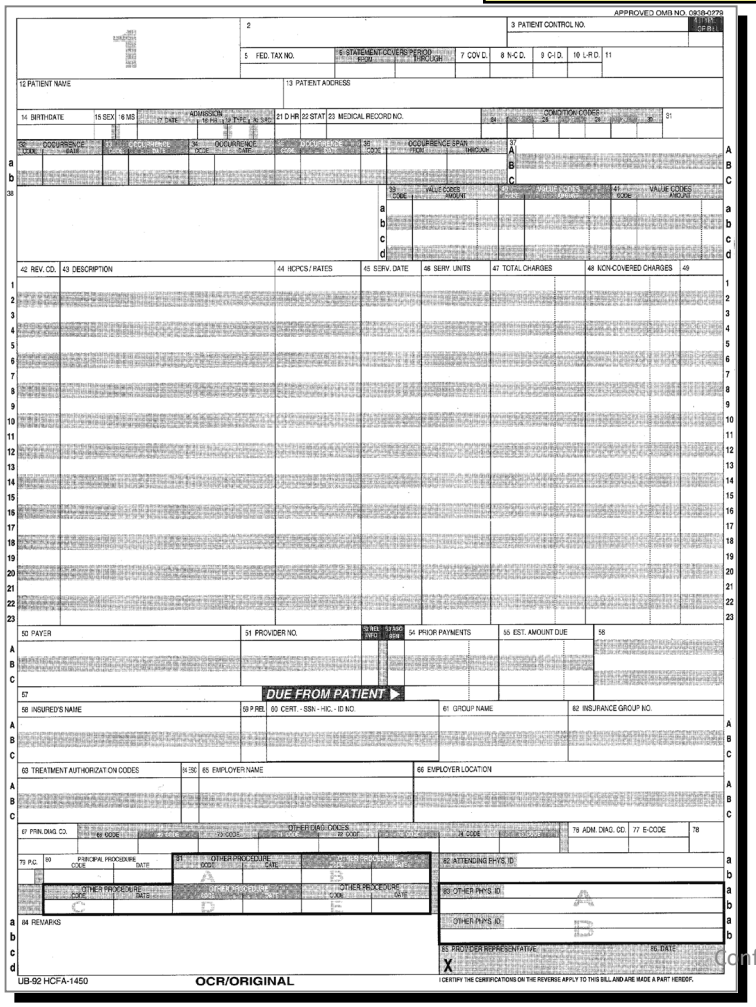
The provision of accurate coding and billing information will help mitigate delays due to denials for missing or incorrect information.

Revenue Cycle – Where Does the Information Come From?

Required Elements:

Required Billing Elements - Where do they come from?

50% - Patient Access, Registration
15% - Medical Records
15% - Charge Entry Areas
20% - Billing



Patient Demographic Data

- ☑ Patients last name, first name, and middle initial
- ☑ Patient address
- ☑ Birth date
- ☑ Male (M) or Female (F)
- ☑ Marital Status
- ☑ Admission date or start of care date

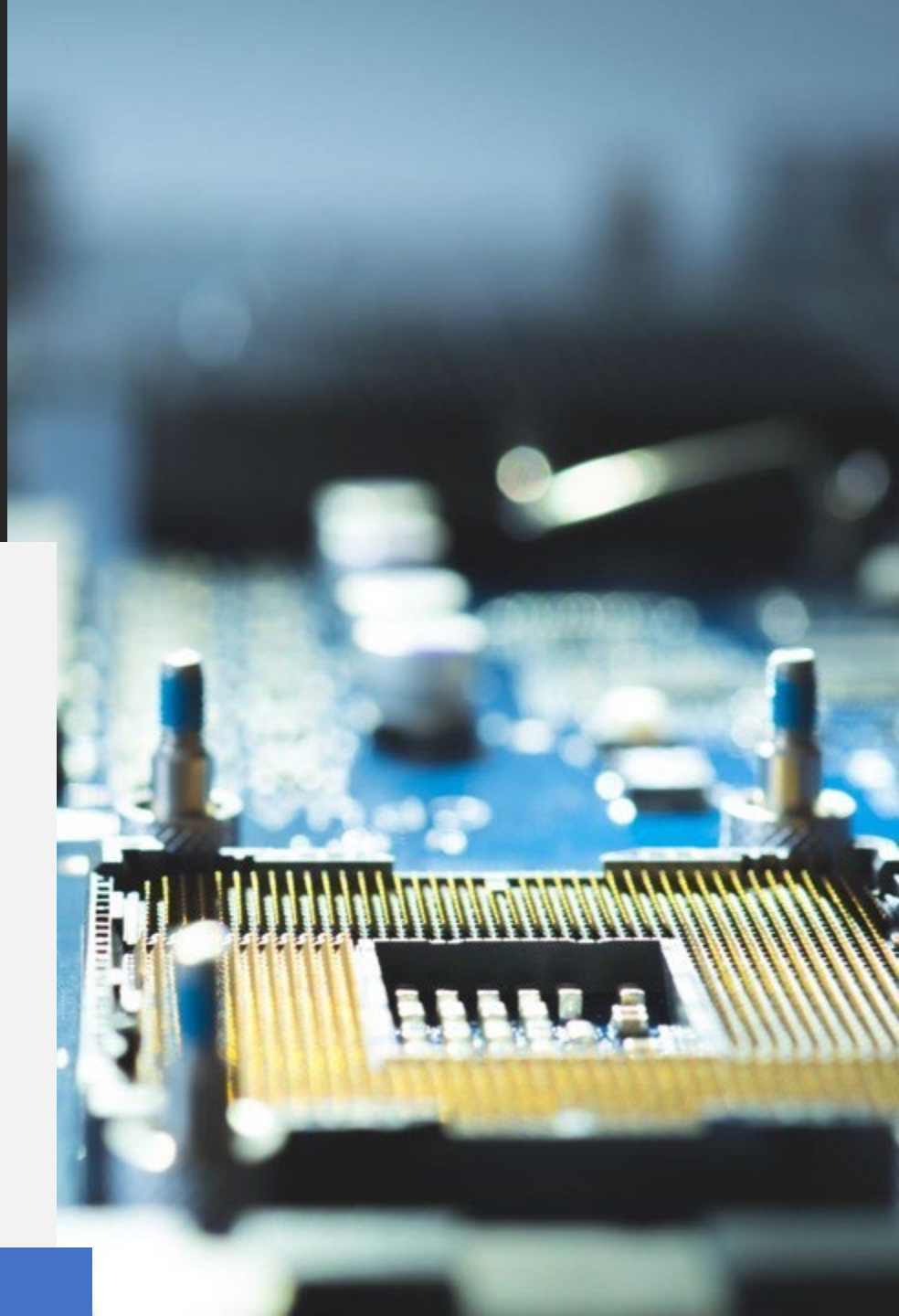
Encounter Specific

- ☑ Hour patient was admitted for inpatient or outpatient care
- ☑ Occurrence Codes
- ☑ Code indicating the priority of admission--1 indicates emergency; 2 urgent; 3 elective; 4 newborn; and 9 information not available.
- ☑ Code indicating the source of admission or outpatient service
- ☑ Provider has patient signature on file permitting release of data (Y or N)
- ☑ Principal Diagnostic Coding (ICD-9-CM code)
- ☑ Admitting Diagnostic Coding (ICD-9-CM code)

Insurance Information

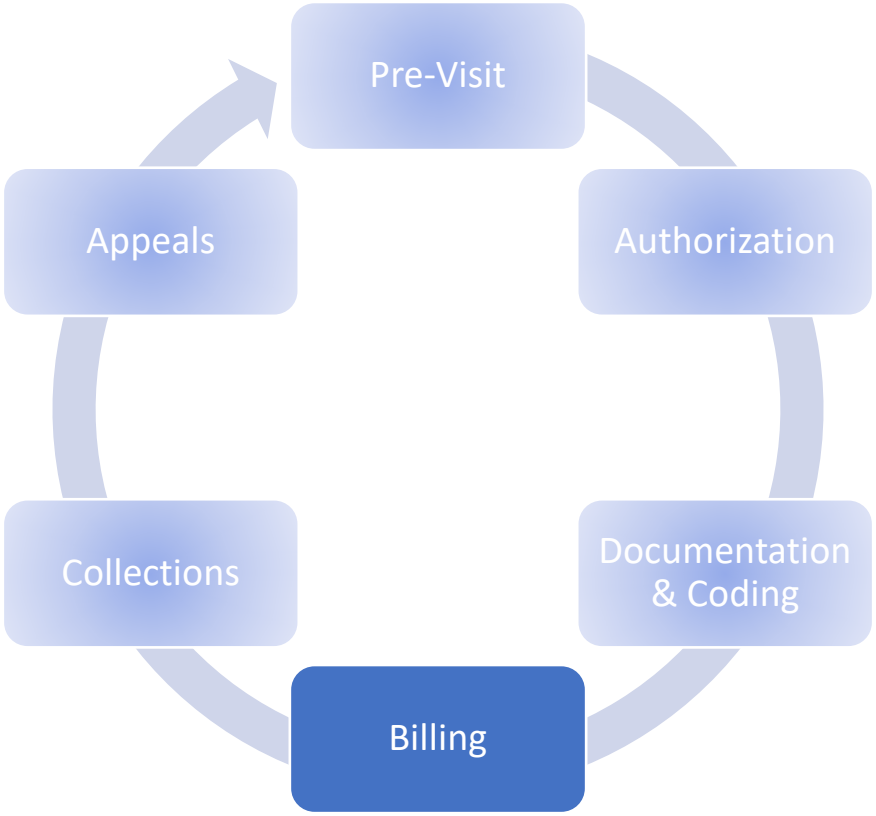
- ☑ The name and number identifying each payer that payment is expected
- ☑ Assignment of benefits (Y) yes; (N) no
- ☑ The name of the patient or insured individual
- ☑ Relationship of the insured (person having insurance) to the patient
- ☑ Insured's identification number assigned by the payer organization
- ☑ The group name/plan through which the insurance coverage is provided
- ☑ The insurance group number
- ☑ Employment status code
- ☑ Employer's name and address

Where Do Codes Come From?



- A Superbill (Offices) is a manual or electronic
  - List of diagnosis codes (maybe)
  - List of procedure codes
  - List of drug HCPCS codes
- Must be updated quarterly for changes and this is a source of errors
- These selected codes are then posted to bills either manually or electronically-–usually the night after service

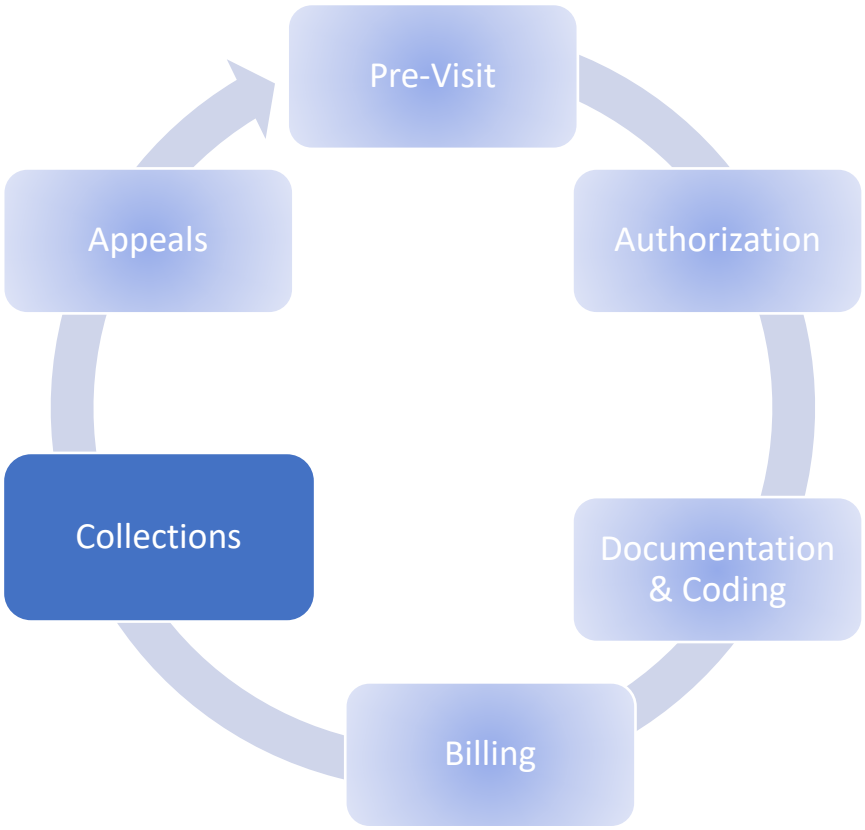
Other Information that May Be Needed to Bill



- Prior Authorization proof or insurance-issued number
- Certificate of Medical Necessity
- Medical record submission
- Letter of Medical Necessity
- Telephonic review with the physician
- National Drug Code number
- The FDA approval letter or package insert

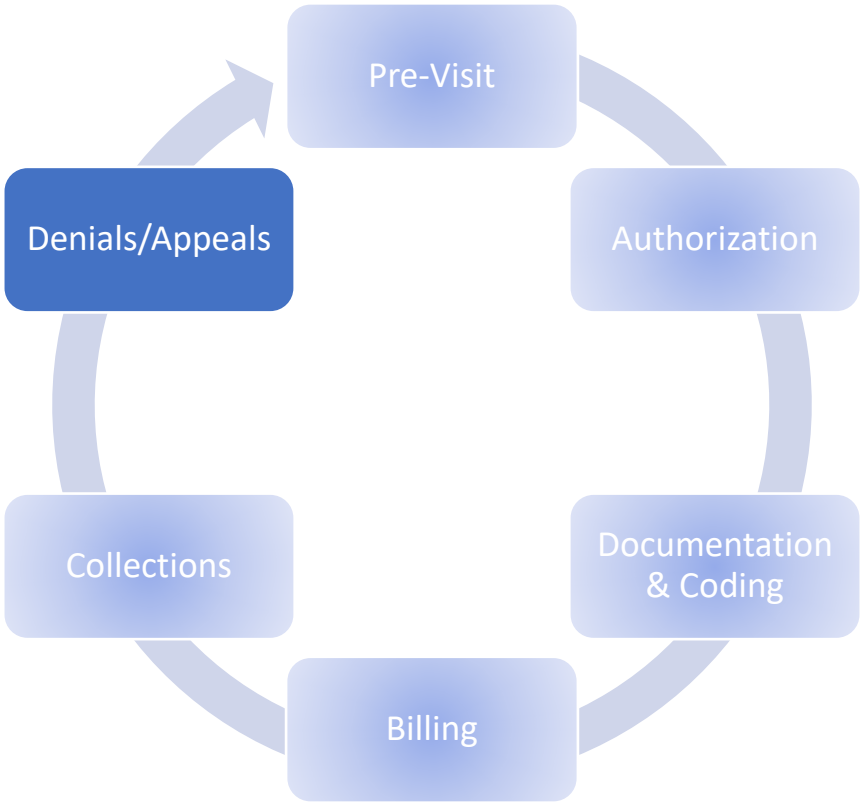
Expect that payers will require more documentation for miscellaneous J code drugs and be prepared to provide.

Collections



Collections usually refers to collecting the patient portion of the bill

And Know That Denials Will Happen



Common Denial Reasons According to the AMA

1. Missing Information
2. Duplicate Claims
3. Service already adjudicated
4. Not covered by this payer
5. Time limit for filing has expired

What is A Denial?

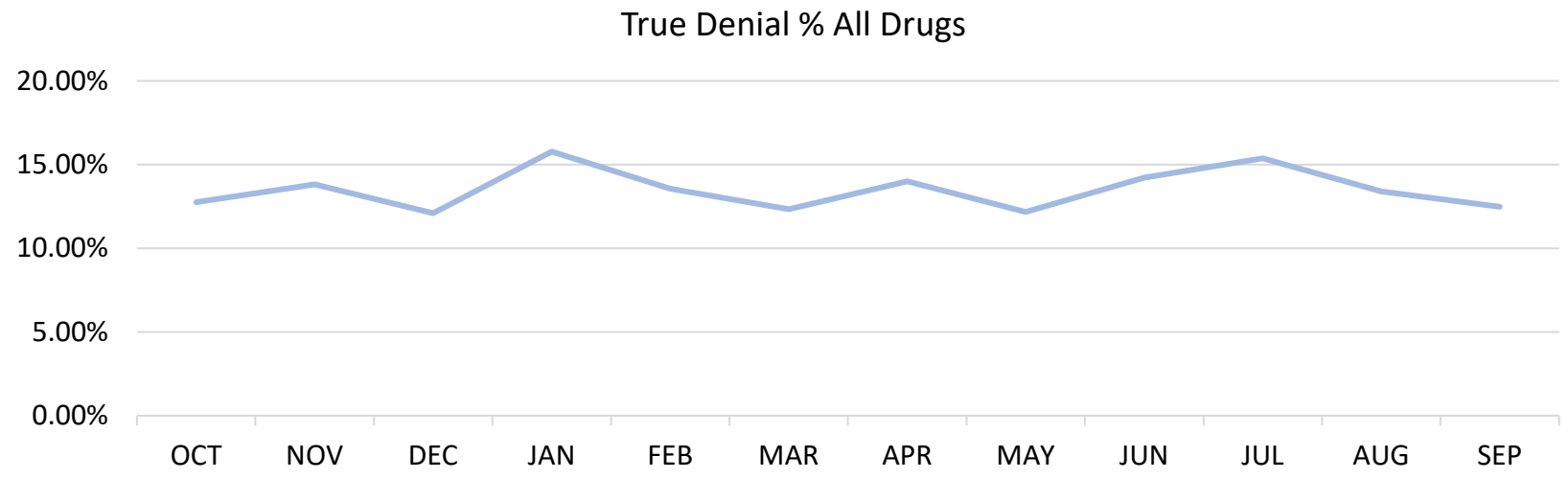
- A denial is a “contract dispute,” and an appeal must be based both on the reason for the denial and the provisions in the insurance policy, contract, or payer guidelines that are supported by the insurance contract.
- According to focalPoint data, most 2020 denials are administrative omissions as seen by the payer.

Basic Steps of Appeals

1. Know the benefits of the patients plan or plans
2. Clearly understand the REASON the claim is denied
3. Submit proof that the item or service was reasonable and/ or necessary

From: https://www.livestrong.org/we-can-help/insurance-and-financial-assistance/appealing-insurance-claim-denials

Drug Denial Trends 2019-2020



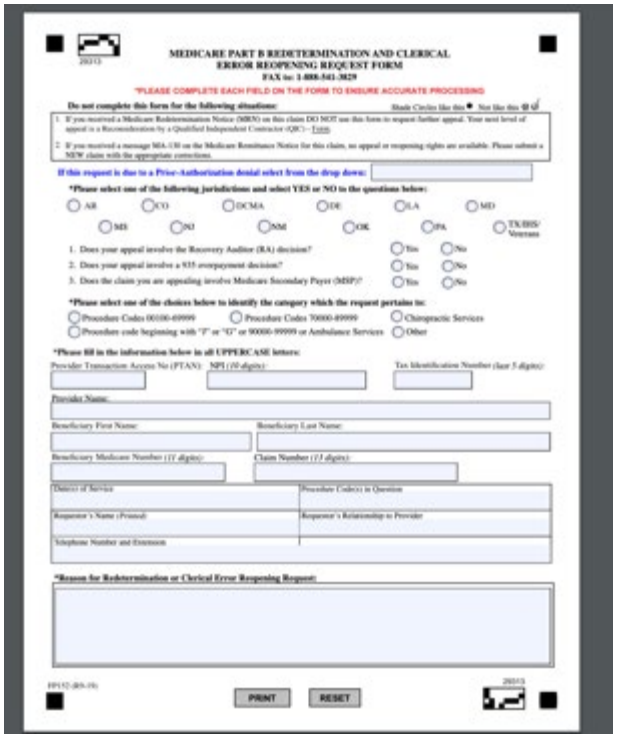
Source: onPoint focalPoint® data

Drug Denial Types 2020 YTD
onPoint focalPoint® Data

Reason Code	Description	True Denials	% of Total True Denials along Reason Code	Area
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation.	84,478	16.75%	Billing
197	Precertification/authorization/notification absent.	45,748	9.07%	Pre-Reg
252	An attachment/other documentation is required to adjudicate this claim/service.	43,795	8.68%	Billing
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	38,131	7.56%	All
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	35,075	6.95%	Billing
50	These are non-covered services because this is not deemed a 'medical necessity' by the payer.	31,583	6.26%	All
29	The time limit for filing has expired.	25,363	5.03%	Billing
22	This care may be covered by another payer per coordination of benefits.	22,083	4.38%	Front Desk
A1	Claim/Service denied.	17,806	3.53%	All
27	Expenses incurred after coverage terminated.	12,822	2.54%	Front Desk

Clerical Error Reopening ("CER")

- CMS defines clerical errors as human or mechanical errors on the part of the party or the contractor, and may include mathematical or computational mistakes, transposed procedure or diagnostic codes, inaccurate data entry, computer errors and some duplicate denials which the party believes were incorrectly identified as a duplicate and incorrect data items, such as provider number, use of a modifier or date of service.



MEDICARE PART B REDETERMINATION AND CLERICAL
ERROR REOPENING REQUEST FORM
FAX to: 1-888-541-3829

*PLEASE COMPLETE EACH FIELD ON THE FORM TO ENSURE ACCURATE PROCESSING

Do not complete this form for the following situations:

1. If you received a Medicare Redetermination Notice (MRN) on this claim DO NOT use this form to request further appeal. Your next level of appeal is a Reconsideration by a Qualified Independent Contractor (QIC) – Form
2. If you received a message MIA-130 on the Medicare Remittance Notice for this claim, no appeal or reopening rights are available. Please submit a NEW claim with the appropriate corrections.

If this request is due to a Prior-Authorization denial select from the drop down:

*Please select one of the following jurisdictions and select YES or NO to the questions below:

AR CO DCMA DE LA MD
MS NJ NM OK PA TX/HHS/ Veterans

1. Does your appeal involve the Recovery Auditor (RA) decision? Yes No
2. Does your appeal involve a 935 overpayment decision? Yes No
3. Does the claim you are appealing involve Medicare Secondary Payer (MSP)? Yes No

*Please select one of the choices below to identify the category which the request pertains to:

Procedure Codes 00100-69999 Procedure Codes 70000-89999 Chiropractic Services
Procedure code beginning with "J" or "Q" or 90000-99999 or Ambulance Services Other

*Please fill in the information below in all UPPERCASE letters:

Provider Transaction Access No (PTAN): NPI (10 digits): Tax Identification Number (last 5 digits):

Provider Name:

Beneficiary First Name: Beneficiary Last Name:

Beneficiary Medicare Number (11 digits): Claim Number (13 digits):

Date(s) of Service	Procedure Code(s) in Question
Requestor's Name (Printed)	Requestor's Relationship to Provider
Telephone Number and Extension	

*Reason for Redetermination or Clerical Error Reopening Request:

PRINT RESET

CER Form from Medicare

What Can Be Re-opened

- The following issues can be addressed as a reopening for billing and clerical errors:
  - Number of units billed
  - Adding a diagnosis code
  - Changing a CPT code
  - Changing a date of service
  - Adding modifiers (with some restrictions)
  - Changing billed amounts
  - Cancel claim request
  - Place of Service
  - Rendering Provider NPI
  - Duplicate services
  - Services that should not have been billed to Medicare

What Cannot Be Re-Opened

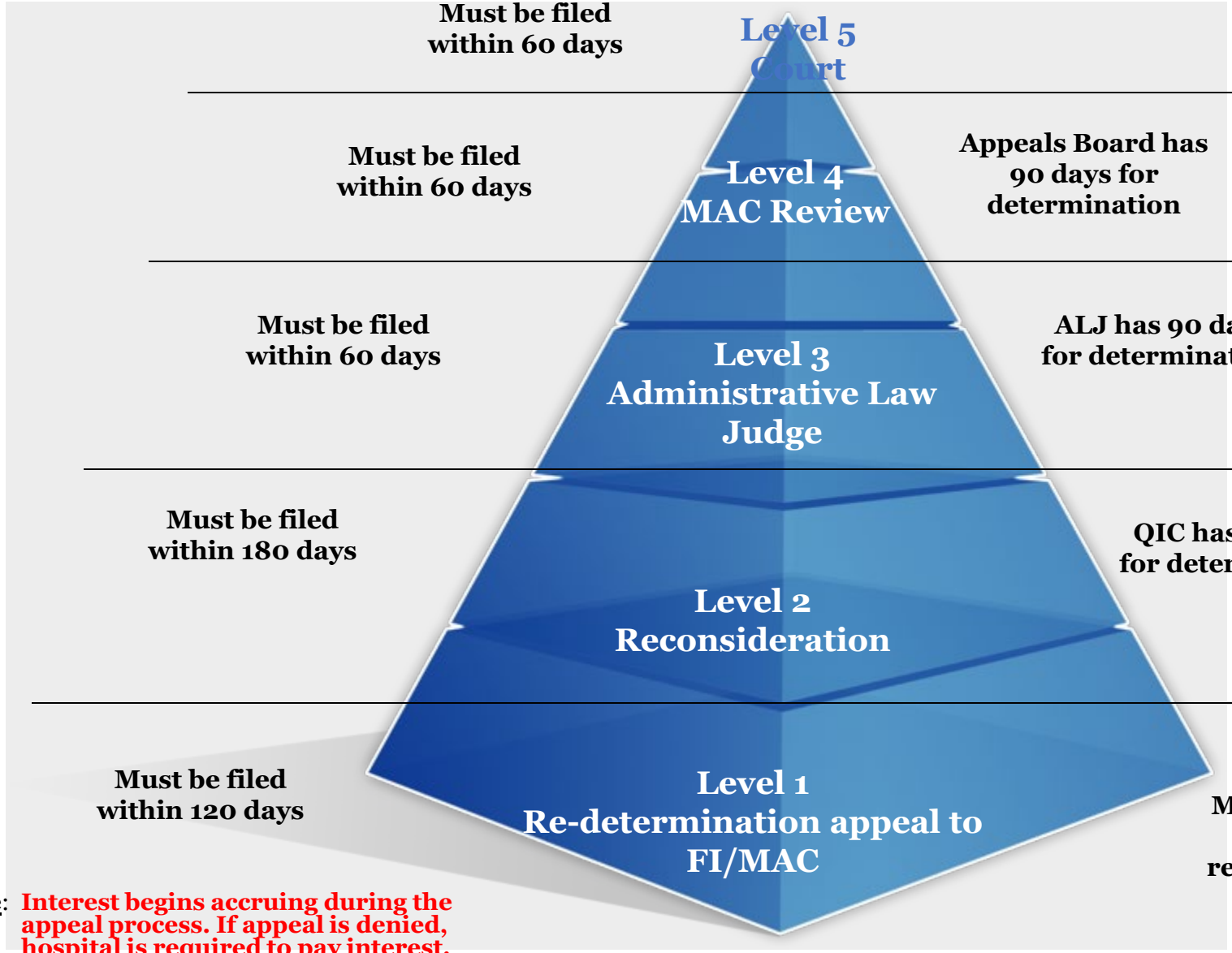
- The following issues cannot be requested as a reopening:
  - Any denied line item on a partially paid claim
  - Any denied line item by Medical Review
  - MUE edit rejections
  - Ambulance services
  - Medicare Secondary Payer (MSP) issues
  - Issues where a Recovery Auditor (RAC) demand letter is involved

Types of Services That May be Appealed

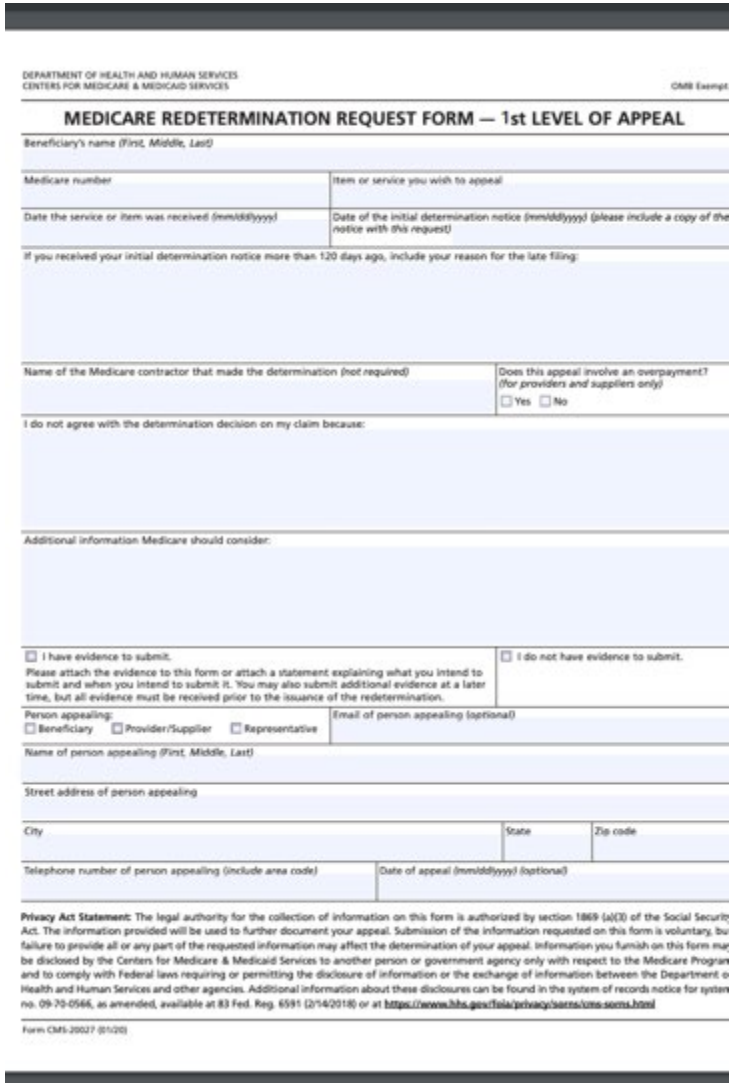
- Coverage of furnished items and service
- Application of coinsurance provision
- Number of lifetime reserve days used
- Physician certification requirement
- Beginning and ending of a benefit period
- A determination with respect to limitations of liability provision
- CERT denials
- RAC denials
- Amount of deductible
- Number of inpatient hospital days used toward 190-day lifetime limitation of inpatient psychiatric hospital covered days
- Number of SNF days used
- Any issue(s) affecting the amount of benefits payable (including overpayments or underpayments)
- Medical necessity of services
- Benefit integrity support center denials
- Prepay and postpay probes

From NGS Medicare

Medicare Levels of Appeal



Note: **Interest begins accruing during the appeal process. If appeal is denied, hospital is required to pay interest.**



DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB Exempt

MEDICARE REDETERMINATION REQUEST FORM — 1st LEVEL OF APPEAL

Beneficiary's name *(First, Middle, Last)*

Medicare number

Item or service you wish to appeal

Date the service or item was received *(mm/dd/yyyy)*

Date of the initial determination notice *(mm/dd/yyyy) (please include a copy of the notice with this request)*

If you received your initial determination notice more than 120 days ago, include your reason for the late filing:

Name of the Medicare contractor that made the determination *(not required)*

Does this appeal involve an overpayment? *(for providers and suppliers only)*
☐ Yes ☐ No

I do not agree with the determination decision on my claim because:

Additional information Medicare should consider:

☐ I have evidence to submit.
Please attach the evidence to this form or attach a statement explaining what you intend to submit and when you intend to submit it. You may also submit additional evidence at a later time, but all evidence must be received prior to the issuance of the redetermination.

☐ I do not have evidence to submit.

Person appealing:
☐ Beneficiary ☐ Provider/Supplier ☐ Representative

Email of person appealing *(optional)*

Name of person appealing *(First, Middle, Last)*

Street address of person appealing

City

State

Zip code

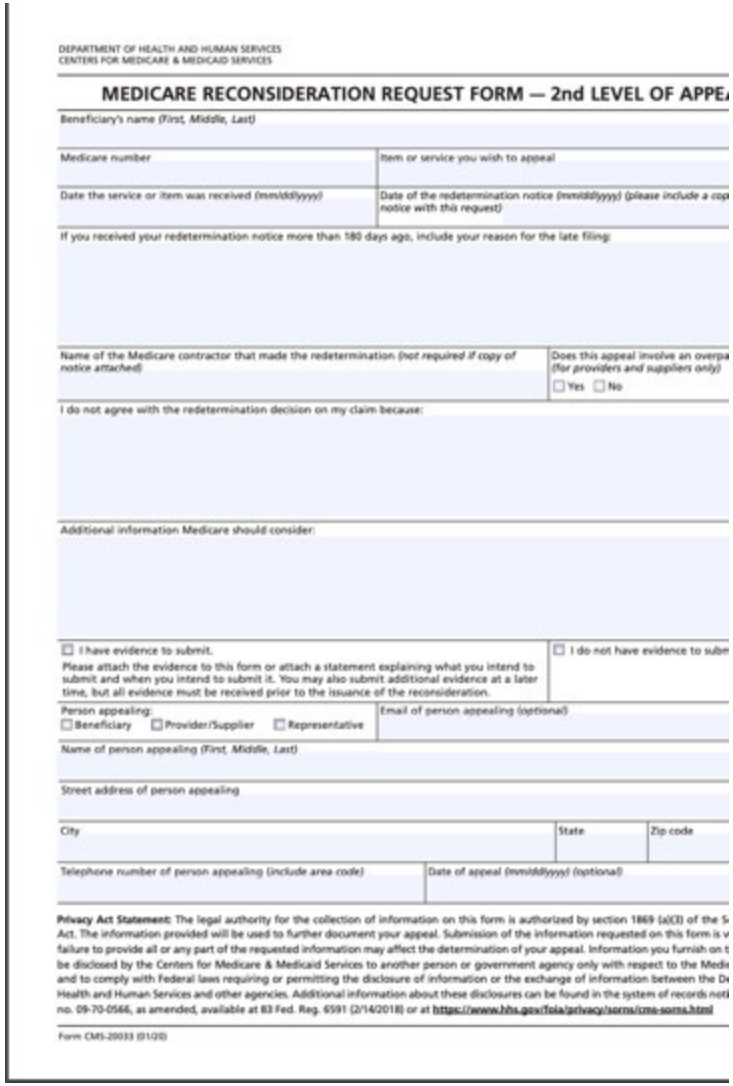
Telephone number of person appealing *(include area code)*

Date of appeal *(mm/dd/yyyy) (optional)*

Privacy Act Statement: The legal authority for the collection of information on this form is authorized by section 1869 (a)(3) of the Social Securit Act. The information provided will be used to further document your appeal. Submission of the information requested on this form is voluntary, bu failure to provide all or any part of the requested information may affect the determination of your appeal. Information you furnish on this form ma be disclosed by the Centers for Medicare & Medicaid Services to another person or government agency only with respect to the Medicare Program and to comply with Federal laws requiring or permitting the disclosure of information or the exchange of information between the Department o Health and Human Services and other agencies. Additional information about these disclosures can be found in the system of records notice for systen no. 09-70-0566, as amended, available at 83 Fed. Reg. 6591 (2/14/2018) or at https://www.hhs.gov/foia/privacy/sorns/cms-sorns.html

Form CMS-20027 (01/20)

Appeals First Level



DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE RECONSIDERATION REQUEST FORM — 2nd LEVEL OF APPE

Beneficiary's name (First, Middle, Last)

Medicare number | Item or service you wish to appeal

Date the service or item was received (mm/dd/yyyy) | Date of the redetermination notice (mm/dd/yyyy) (please include a cop notice with this request)

If you received your redetermination notice more than 180 days ago, include your reason for the late filing:

Name of the Medicare contractor that made the redetermination (not required if copy of notice attached) | Does this appeal involve an overpa (for providers and suppliers only) ☐ Yes ☐ No

I do not agree with the redetermination decision on my claim because:

Additional information Medicare should consider:

☐ I have evidence to submit. | ☐ I do not have evidence to subm

Please attach the evidence to this form or attach a statement explaining what you intend to submit and when you intend to submit it. You may also submit additional evidence at a later time, but all evidence must be received prior to the issuance of the reconsideration.

Person appealing: ☐ Beneficiary ☐ Provider/Supplier ☐ Representative | Email of person appealing (optional)

Name of person appealing (First, Middle, Last)

Street address of person appealing

City | State | Zip code

Telephone number of person appealing (include area code) | Date of appeal (mm/dd/yyyy) (optional)

Privacy Act Statement: The legal authority for the collection of information on this form is authorized by section 1869 (a)(3) of the S Act. The information provided will be used to further document your appeal. Submission of the information requested on this form is v failure to provide all or any part of the requested information may affect the determination of your appeal. Information you furnish on t be disclosed by the Centers for Medicare & Medicaid Services to another person or government agency only with respect to the Medi and to comply with Federal laws requiring or permitting the disclosure of information or the exchange of information between the De Health and Human Services and other agencies. Additional information about these disclosures can be found in the system of records noti no. 09-70-0566, as amended, available at 83 Fed. Reg. 6591 (2/14/2018) or at https://www.hhs.gov/foia/privacy/sorns/cms-sorns.html

Form CMS-20033 (01/20)

Appeals Second Level

Appeals Third Level

Forms Needed for Your Level 3 Appeal

Below is a list of **Level 3 forms only** that may pertain to your request for a hearing by an Administrative Law Judge.

- Request or Waive an Administrative Law Judge Hearing with OMHA
- Pre-Hearing Forms Needed by OMHA
- Records, Record Change, and Information Requests
- Request for Substitution Upon Death of Beneficiary
- Petition to Obtain Approval of a Fee for Representing a Beneficiary
- Request to Escalate Your Appeal
- After your Appeal

https://www.hhs.gov/about/agencies/omha/filing-an-appeal/forms/index.html#1

SEE APPENDICES for Parts C and D Appeals

Appeal Commercial/Medicaid Claims

- Check your contracts for each insurance's appeal process.
- You have the right to appeal a health insurance company's decision to deny payment for a claim. The following rules for appeals apply to health plans created after March 23, 2010, and to older plans that have been changed in certain ways since that date.
  - You or the beneficiary can appeal the insurance company's decision through an "internal appeal", in which you ask your insurance company to do a full and fair review of its decision. If your insurance company still denies payment or coverage, the law permits you to have an independent third party decide to uphold or overturn the plan's decision. This final process is often referred to as an "external review".
  - Your state may have a Consumer Assistance Program that can help you file an appeal or request a review of your health insurance company's decision if you are not sure what steps to take. Your insurance company should have provided you with information about how to file an appeal and the appeals process when the patient enrolled in coverage, and there may be information about the process on the plan's website. Visit LocalHelp.HealthCare.gov to find help in your area.

Buy and Bill Metrics

- Days to File
- Days to Pay
- Accounts Receivable Aging
- Average Daily Cash Received
- Net Working Capital
- Dollars Earned from Uninsured and Underinsured Patients

Physician Reimbursement

Except For Drugs

Diagnosis Codes

Clinicians select “ICD-10-CM” codes to describe a patient’s diagnoses, symptoms, and clinical findings.

ICD = International Classification of Diseases. Established by the World Health Organization for international reporting of epidemiology, morbidity, and mortality.

ICD-CM = ICD-10-Clinical Modification. Used in the USA for clinical coding, it is derived from ICD-10 and contains greater clinical detail as necessary for clinical care.

Diagnosis Codes

Clinicians select “ICD-CM” codes to describe a patient’s diagnoses, symptoms, and clinical findings.

Service Codes

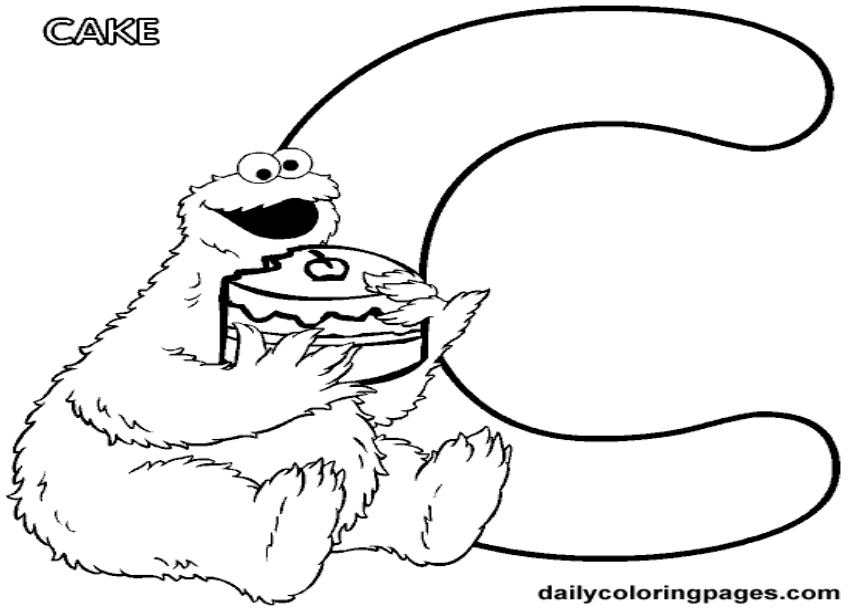
They then select “CPT” codes to describe the services provided to care for the identified clinical conditions.

CPT = Current Procedural Terminology, a registered trademark of the American Medical Association. CPT is developed by the AMA. The “CPT” trademark acronym is used in this presentation only for general education purposes. CPT official content is available for purchase from the AMA.

ICD-CM diagnosis codes determine the medical necessity for provided CPT services or HCPCS for drugs or supplies. Therefore, accuracy and specificity of diagnosis coding is essential for appropriate service payment.

Bonus of ICD-10-CM

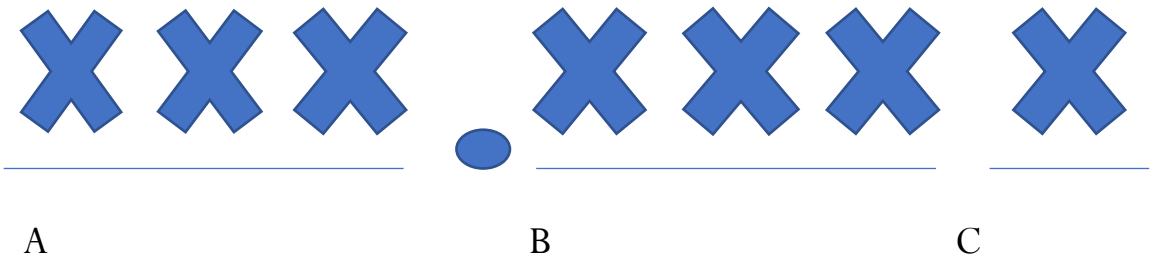
- **Cancer (Neoplasm) Codes Begin With C!!!!**



Comparison of ICD-9-CM and ICD-10-CM

- ICD-10-CM CODE

- A - Category of code
- B - Etiology, anatomical site, and/or severity
- C - Extension
  - 7th character for obstetrics, injuries, and external causes of injury



ICD-10-CM Codes for Multiple Myeloma

C90.00—Multiple Myeloma, not having achieved remission

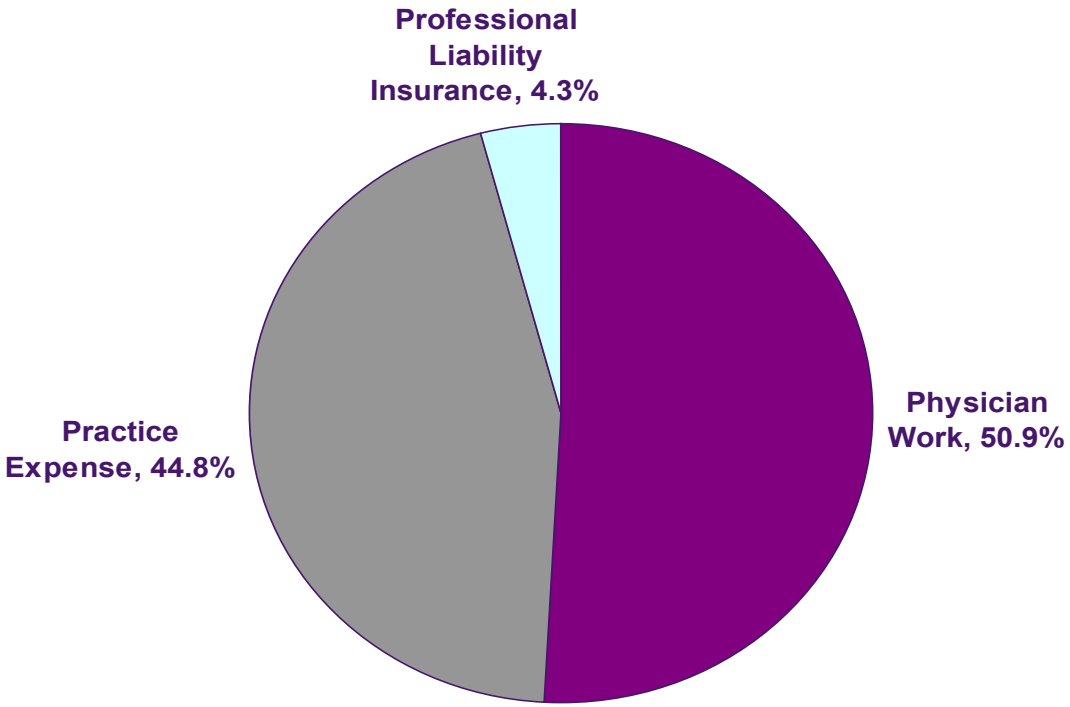
C90.01---Multiple Myeloma, relapsed

C90.02—Multiple Myeloma, in remission

Biggest ICD-10-CM Coding Issues in Multiple Myeloma

- Use of the Z51.-”Encounter” codes for drugs with multiple indications or even a single indication.
- Use of the “in remission” code for patients under treatment.
- Non-use of the ‘relapsed’ code for 2nd and 3rd line drugs.

Components of the RBRVS (The Resource-Based Relative Value System)
Used by 90% of Physician Payers for Services
Percent of Total Relative Value



Medicare RBRVS

- Payments are calculated by multiplying the combined costs of a services by a conversion factor (a monetary amount that is determined by the Centers for Medicare and Medicaid Services with Congressional approval)
- Payments are also adjusted for geographical differences in resource costs (geographic practice cost index (GPCI))

Calculating Payment

- The general formula for calculating Medicare payment amounts for January 1- December 31, 2017 is expressed as:

  Total RVU =

  [(work RVU x work GPCI)

  + (practice expense RVU x practice expense GPCI)

  + (malpractice RVU x malpractice GPCI)]

  Total RVU x Conversion Factor* = Medicare Payment

  **The Conversion Factor for CY 2020* = The 2020 Medicare physician fee schedule conversion factor is $36.0896; we expect a slight increase by statute for 2021.

Private Payer Use of RBRVS

Use the relative values released by The Centers for Medicare and Medicaid Services annually for fee-for-service contracts

Establish a negotiated conversion factor with contracting providers

May have additional payments for quality and/or risk-sharing

More Coding and Billing

Later!

Introduction to Hospital Reimbursement

Section Objectives

- To demarcate the similarities and differences between offices and hospital-based cancer centers
- To explain how provider-based drugs fit into the the hospital's cost and revenue structure
- To quantify the impact on patients from the shift to hospital-based cancer care

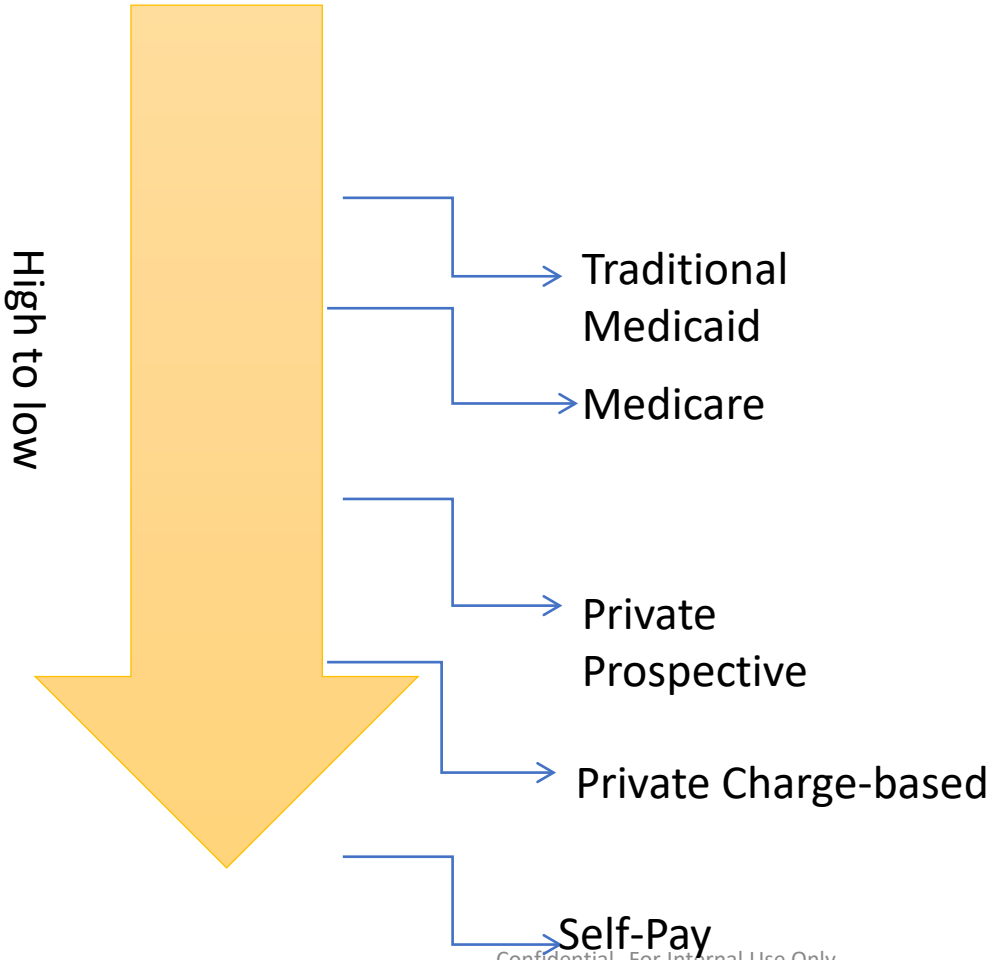
Changes in Community Oncology (Source: 2020 COA Practice Impact Report)

	2010 Report	2011 Report	2012 Report	2013 Report	2014 Report	2016 Report	2018 Report	2020 Report
Clinics Closed	172	199	241	288	313	380	423	435
Struggling Financially	323	369	442	407	395	390	359	348
Sending Patients Elsewhere	44	48	47	43	46	45	45	40
Acquired by Hospital	224	315	392	469	544	609	658	722
Merged or Acquired	102	111	132	131	149	157	168	203
Totals	865	1,042	1,254	1,338	1,447	1,581	1,653	1,748

The Hospital Revenue Cycle

Differences With Community Oncology

Payer Class and Contractual Adjustments (Hospitals)--Outpatient



A Contractual Adjustment is a part of a patient's bill that a doctor or hospital must write-off (not charge for) because of billing agreements with the insurance company. Adjustments, or write-off's, are the dollars that are adjusted off a patient account for any reason. The Contractual Adjustment is the most common type of adjustment.

Medicaid Reimbursement

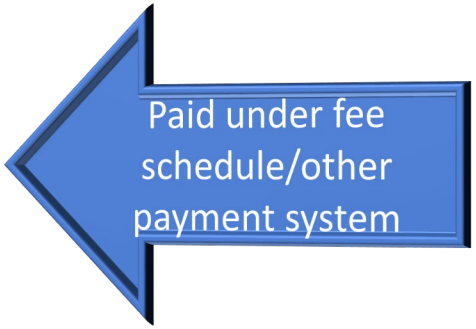
- Outpatient
  - Traditional Medicaid can be based on
    - A negotiated rate based on cost-to-charge ratio, which may be a part of a competitive bidding process; drugs paid separately
    - A negotiated rate per case for a cycle of treatment defined by treatment type, e.g. bone marrow transplant, Radiation for prostate cancer
    - Fee schedules, more similar to Medicare hospital or physician fee schedule
  - Managed Medicaid
    - Capitated payment, i.e. a fixed per-member-per-month figure for all services, except those that are carved out

Medicare Reimbursement

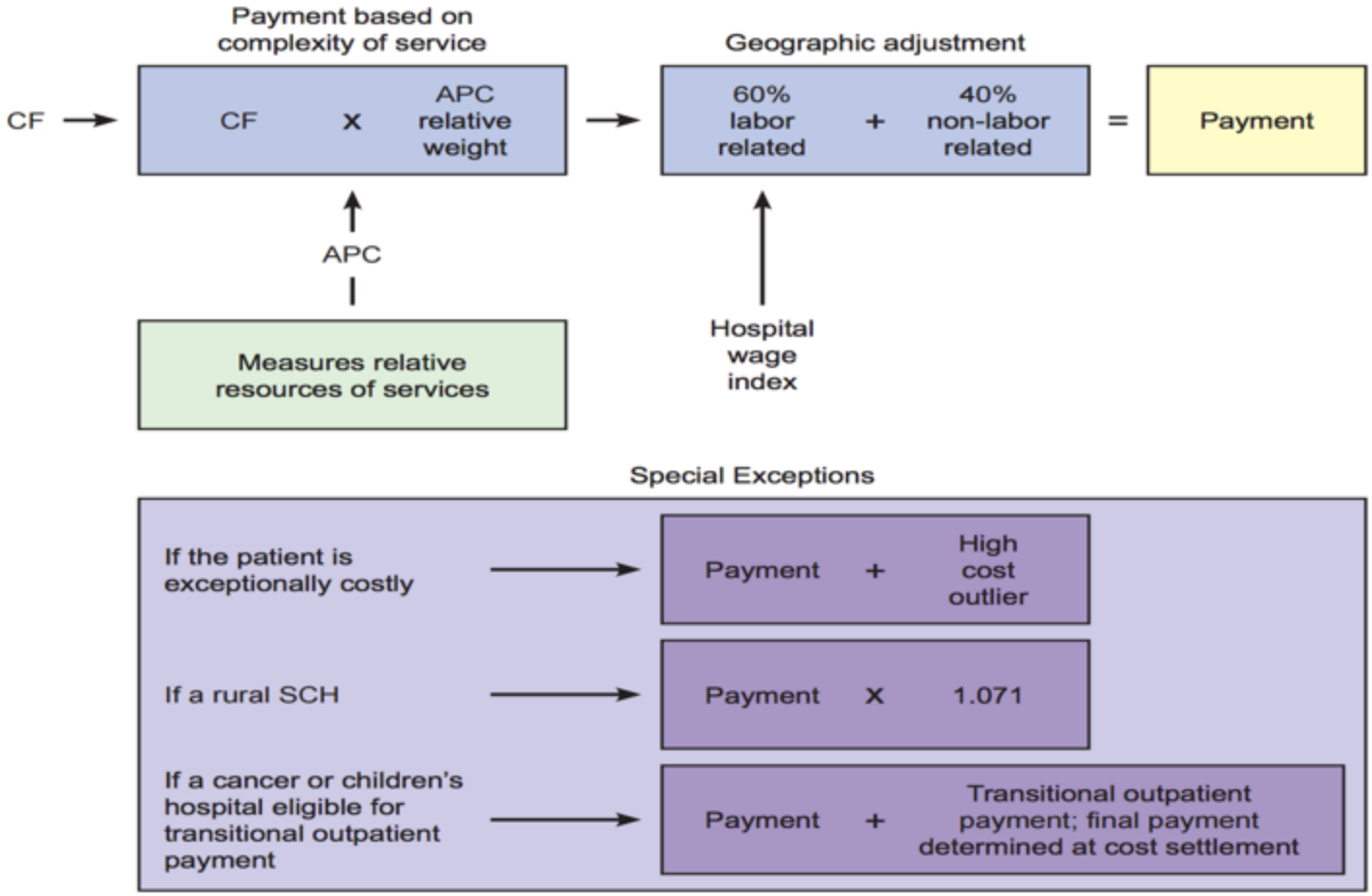
- Outpatient
  - Traditional Medicare
    - **Hospital Outpatient Prospective Payment System** is the outpatient fee schedule called Ambulatory Payment Classifications (APCs) that bundles many items and services into a single payment for facility fees . These include:
      - Drugs under $110 per encounter
      - Labs
      - Supplies
      - Diagnostic drugs
    - Addition + or – 2% for Quality Reporting, unrelated to cancer
    - Pass-through and new drugs at ASP plus 6%
    - Professional fees for hospital-employed physicians—the same as Part B
  - Medicare Advantage
    - Capitation (drugs may be carved out)
    - Fee schedules similar to HOPPS
  - Medicare pays 65% of “true” bad debt to hospitals at the end of each year

Hospital Outpatient Prospective Payment System (OPPS)

- Some hospital outpatient services are not paid under Medicare OPPS
  - Routine dialysis for end stage renal disease (ESRD)
  - Professional services
  - Physical, occupational, and speech therapy
  - Diagnostic and screening mammography
  - Flu and pneumonia vaccinations
  - Non-implantable durable medical equipment (DME)
- BUT, SEPARATELY PAID DRUGS ARE PART OF OPPS



Ambulatory Payment Classifications (APC) Reimbursement Calculation



Source: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/HospitalOutpaysysfctsht.pdf

11-Cancer Hospitals: Medicare Exempt

- Medicare Exempt Facilities
    - City of Hope National Medical Center (Duarte, CA)
    - USC Kenneth Norris Jr. Cancer Hospital (Los Angeles, CA)
    - Dana Farber Cancer Institute (Boston, MA)
    - Memorial Hospital for Cancer and Allied Disease (New York, NY)
    - Roswell Park Memorial Institute (Buffalo, NY)
    - American Oncologic Hospital (Fox Chase) (Philadelphia, PA)
    - The University of Texas M.D. Anderson Cancer Center (Houston, TX)
    - Fred Hutchinson Cancer Research Center (Seattle, WA)
    - Arthur G. James Cancer Center Hospital and Research Institute (Columbus, OH)
    - University of Miami Hospital and Clinics (Miami, FL)
    - H. Lee Moffitt Cancer and Research Institute Hospital, Inc. (Tampa, FL)

Cancer Hospital Payments

- Cancer hospitals bill using the same billing codes and forms as every other hospital
- Medicare has determined that outpatient costs incurred by the 11 specified cancer hospitals were greater than the costs incurred by other OPPS hospitals.
  - Therefore, consistent with Section 3138 of the Affordable Care Act, they adopted a policy to provide additional payments to each of the 11 cancer hospitals so that each cancer hospital's final payment to cost ratio (PCR) for services provided in a given calendar year is equal to the weighted average PCR (which we refer to as the "target PCR") for other hospitals paid under the OPPS.
  - The target PCR is set in advance of the calendar year and is calculated using the most recent submitted or settled cost report data that are available at the time of final rulemaking for the calendar year

Medicare Claims Processing Manual Chapter 4 - Part B Hospital, Section 10.6.3

What is a cost report?

- Cost reports are required of all Medicare and Medicaid hospitals. This report is like a tax form and very generally describes:
  - Patient stats
  - Expenses
  - Overhead allocations by department
  - Program gross charges and costs, ratio of costs to charges
  - Financial statements

What gets settled by a cost report?

- The hospital's wage index used to inflate the labor-related portion of inpatient MS-DRG payments and outpatient APC payments
- Disproportionate Share qualification (for being a Disproportionate Share Hospital) and annual adjustments paid for each inpatient discharge. Being a DSH hospital provides the option to be 340B-eligible.
- Direct and Indirect Medical Education adjustments for inpatient payments
- Bad debt settlement
- And more…commercial charge-based payers may use the cost report's ratio of cost-to-charge to determine their payment rates

Source: http://www.ma-ri-hfma.org/edudocs/, *Beyond The Medicare Cost Report: How It Is Used*

Private Insurance Reimbursement (Prospective)

- Outpatient
  - Capitation with certain items and services carved out (usually cancer drugs)
  - A fee schedule based on HOPPS or other versions of Ambulatory Payment Classifications, like HOPPS but with less bundling including for drugs
  - Case rates for certain outpatient surgeries and Radiation Oncology by diagnosis, e.g. prostate cancer, brain cancer

Private Insurance (Fee-for-Service)

- There is still payment, particularly on the outpatient side, which is reimbursed based on what a hospital charges---what percentage is unknown. Here are some of the methodologies:
  - Percentage of charges
  - Ratio of cost to charges (RCC)
  - Cost-to-charge ratio (CCR)
- Drugs may be paid this way, as we shall see…

The Uninsured

- There are two types of uninsured in hospitals:
  - **Indigent patients**: Patients who are below or over the Federal Poverty Limits by a percentage set by Hospital Attorneys. These patients are not self-pay:
    - **They are qualified for Medicaid or local indigent reimbursement**
    - **They are paid through charity care, if they qualify with the hospital's or its foundation's parameters (non-profits only)**
  - **Self-pay**
    - These are people have no insurance (and are not poor) and pay what the hospital charges or negotiate a rate for a procedure, treatment, or patient stay; or
    - In some for-profit hospitals, some payers are not accepted, so patients become self-pay and pay what they are charged or go elsewhere

Physicians and Hospitals Both Involved in Quality Incentives

Hospital quality programs have more history and there are more facets to their efforts.

Still, with health reform, there are many similarities:

- Value-based Purchasing
- Incentives and disincentives for reporting
- Health Technology Meaningful Use Programs
- Publishing of outcomes on public websites

Summary of Hospital Reimbursement Methods

TABLE 5-3 Reimbursement Methods by Payer Category*

	Service Level and Reimbursement Methods		
Payer Category	**Hospital Outpatient Services**	**Hospital Inpatient Services**	**Hospital Professional and Non-Patient Services**
Government programs Medicare, TRICARE, Medicaid (implemented under Prospective Payment	Ambulatory payment classification (APC)	Diagnosis Related Group (DRG)	Resource-based relative value scale (RBRVS)
PPS method basis	Hospital is reimbursed a set fee based on the APC payment rate for the procedure performed	Hospital is reimbursed a set fee based on DRG payment rate for the patient's condition and related treatment.	A relative value is assigned to each CPT code, which represents physician time, skill, and overhead
Commercial and other third-party payers Blue Cross/Blue Shield, Aetna, Humana, Worker's compensation	Case rate Contract rate Fee-for-service Fee schedule Percentage of accrued charges	Case rate Contract rate Fee-for-service Flat rate Percentage of accrued charges Per diem	Fee-for-service Fee schedule Relative value scale (RVU) Usual, customary, and reasonable (UCR)
Managed care plans	Case rate Contract rate	Case rate Contract rate	Capitation Contract Fee schedule

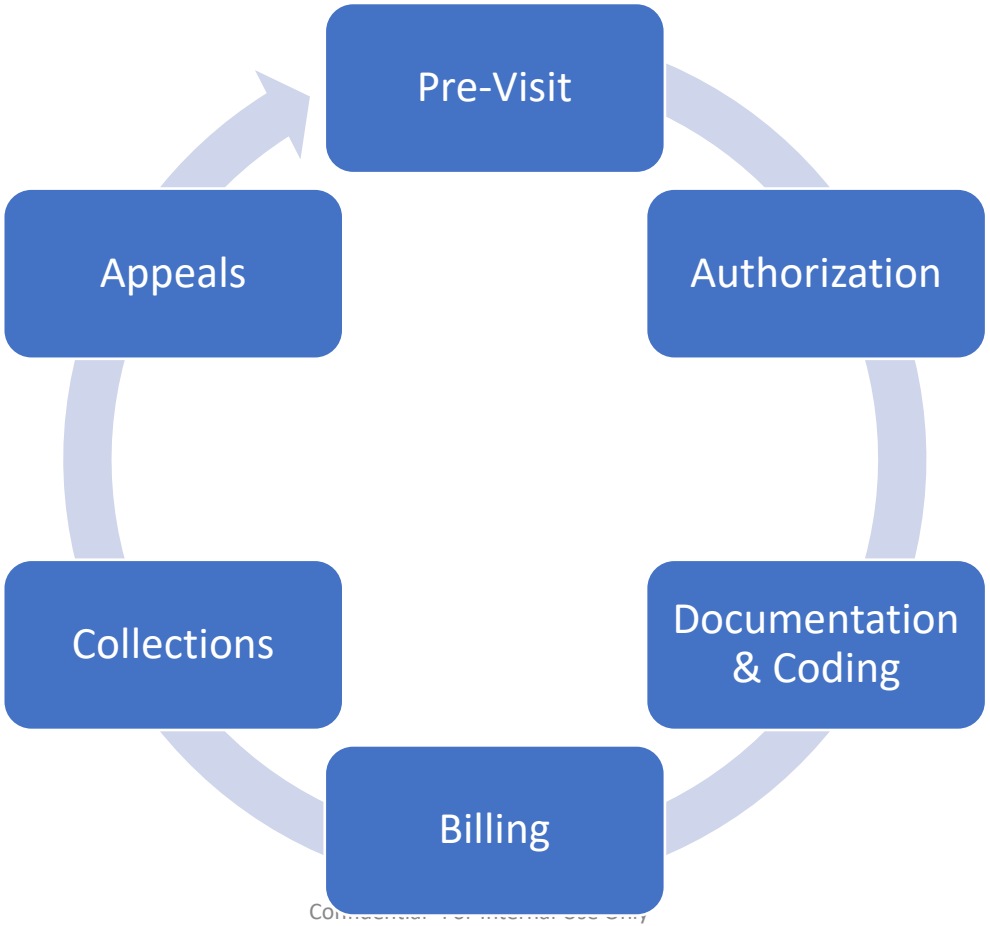
*Many payers are adopting prospective payment–type reimbursement methods.

Source: http://www.coursewareobjects.com/objects/evolve/E2/book_pages/ferenc/pdfs/ch05.pdf

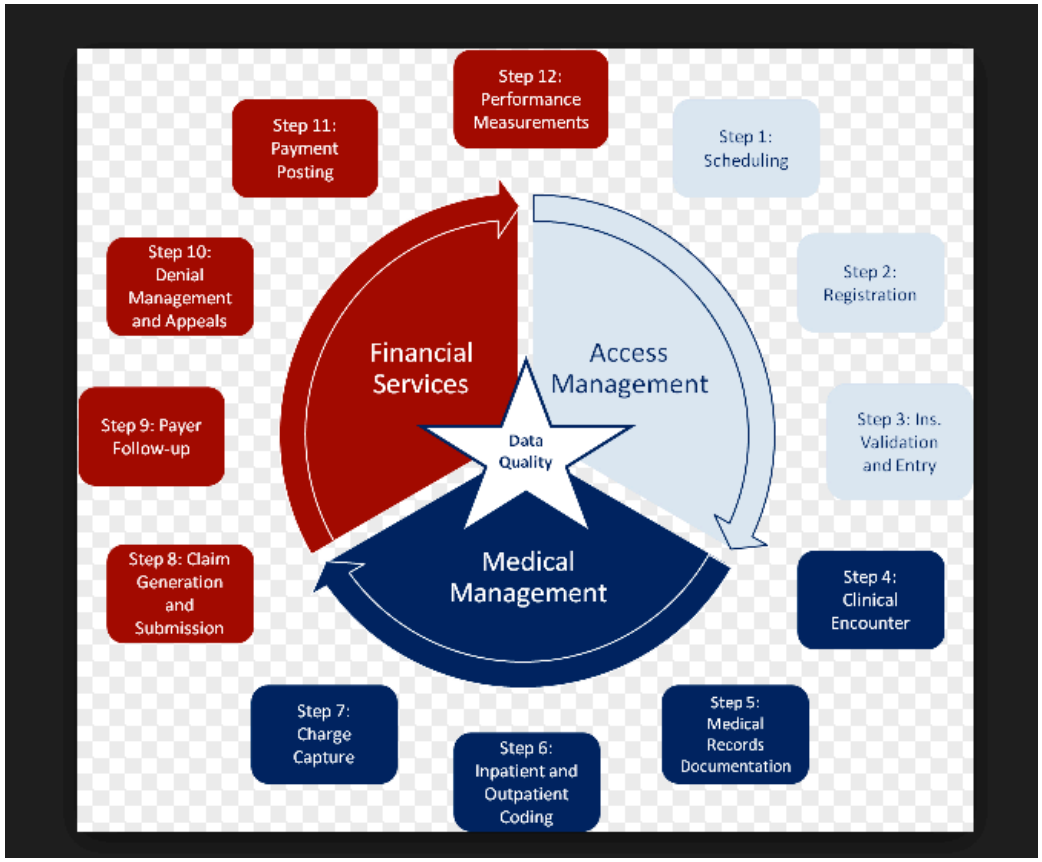
Hospital Revenue Cycle Management

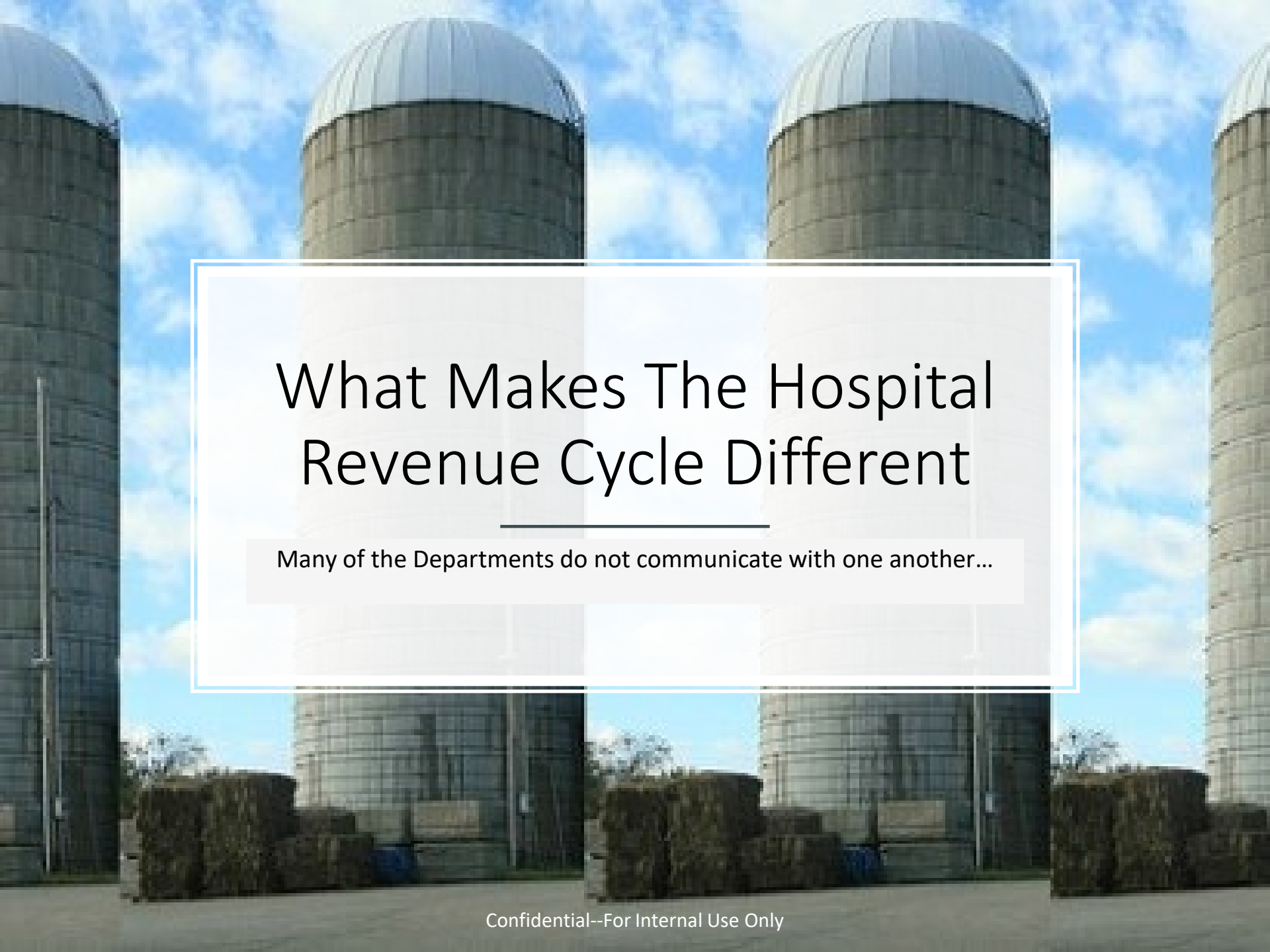
How It Differs from Offices

Revenue Cycle: Office-based Clinics



Revenue Cycle: Hospitals





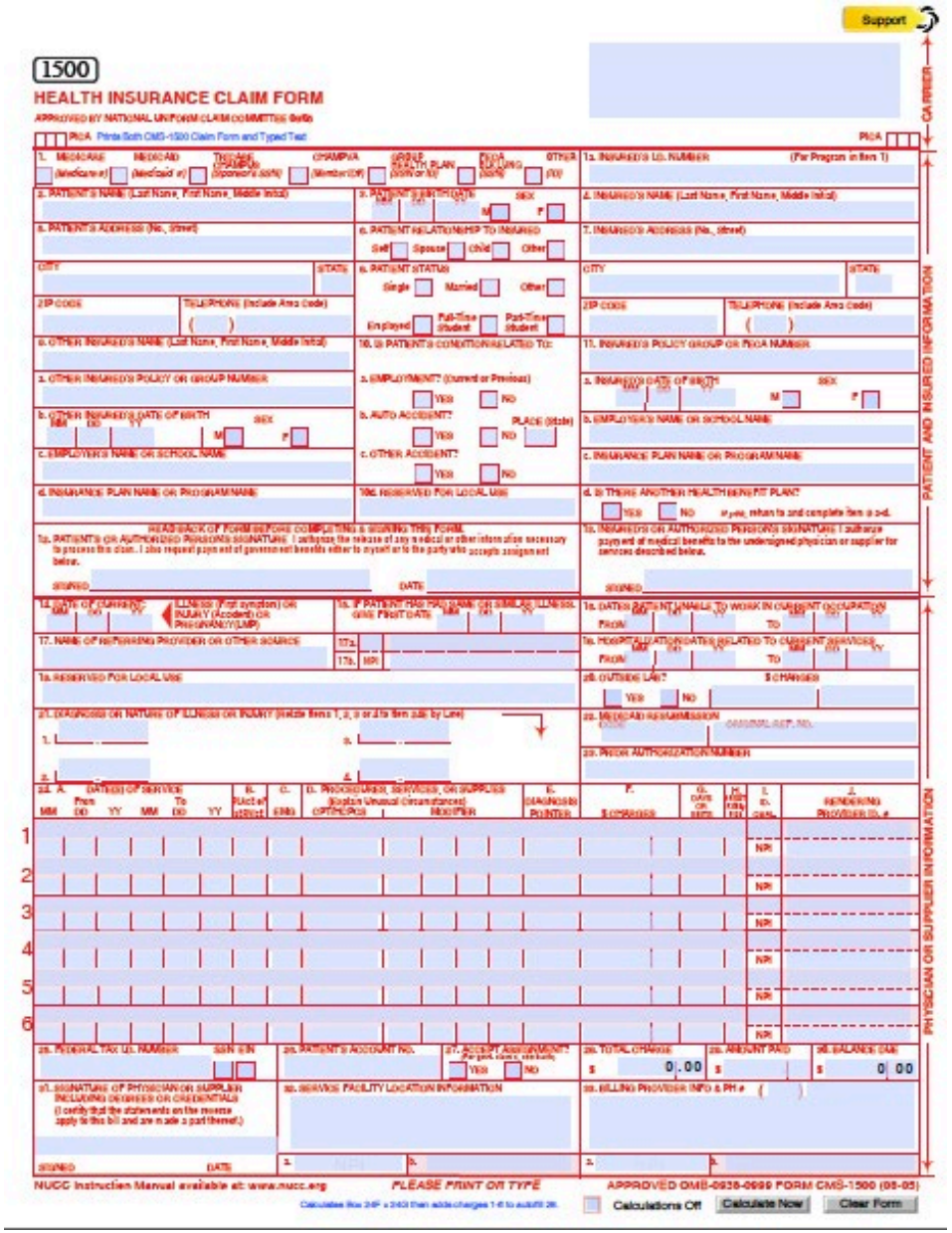
What Makes The Hospital Revenue Cycle Different

Many of the Departments do not communicate with one another…

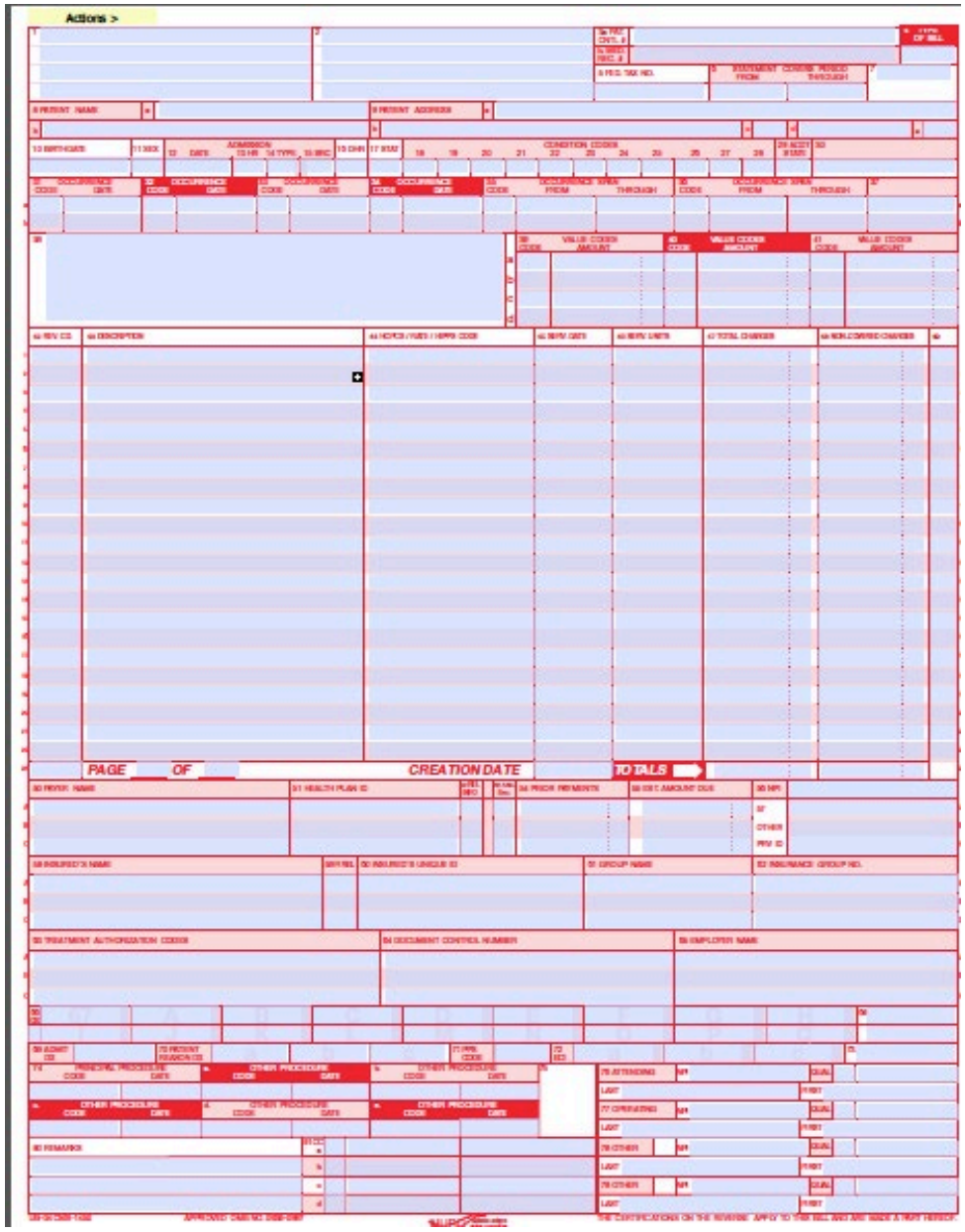
Examples of Departmental Assignments—Revenue Cycle

- Scheduling and Registration—Admissions
- Insurance Verification—Financial Counseling
- Prior authorization—Physician Office or Cancer Clinic
- Coding—Charge Description Master (more about that later)
- Claim Submission & Follow Up—Patient Financial Services
- Denial Management—Varies
- Contract Management—Contracting

The CMS-1500



The CMS-1450 (UB-04 or the Ubie)



The 1500 versus the UB-04

- With the advent of totally electronic billing, there is less difference between the two billing protocols. In fact, in terms of electronic claims, there is very little difference between the two
- However, one distinct data set that hospitals collect is revenue codes. For example:
  - Separately payable drug HCPCS codes are Revenue code 0636 for Medicare
  - IV Chemotherapy Administration is 0335

UB-04 Revenue Codes

Why do third-party payers, including Medicare and Medicaid require revenue codes?

- Revenue codes tell the story of “where” the service was performed and used to be a major part of the Medicare cost report payment method and, because the cost report is still around, revenue codes are still billed
- The four-digit code number has a description (in English)--there are short descriptions (32 characters with abbreviations) and long descriptions
- Only short descriptions appear on the UB-04 due to computer limitations
- Each CPT and HCPCS code has a range of revenue codes that are payer-acceptable

To see the CMS cost center revenue code linkage, go to http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/crosswalk.html

Drug Administration Coding: Offices & Hospitals

It’s Just A Little Different

Coding Systems

Type of Service	Hospital Inpatient	Hospital Outpatient	Physician Office
Diagnosis	ICD-10-CM	ICD-10-CM	ICD-10-CM
Procedure	ICD-10-PCS	CPT	CPT
Drugs	HCPCS	HCPCS	HCPCS

Reasons for CPT Codes

- Coding is medical “shorthand” that allows glimpses into complex medical data in order to:
  - Ascertain the reason for the service or medical diagnosis (ICD-10-CM)
  - Represent a service delivered (CPT®, ICD-10-PCS)
  - Document items delivered (HCPCS, mostly)

What is a Modifier?

Denotes a service or procedure can be further described by using 2-digit **modifiers**. The **Modifier** can be Level I (**CPT**), Level II (HCPCS alpha numeric), and Level III (local) **modifiers**. Level I and II **modifier** definitions are contained in the Healthcare Common Procedure Coding System (HCPCS)

A **modifier** is a code that provides the means by which the reporting physician can indicate that a service or procedure that has been performed has been altered by some specific circumstance but has not changed in its definition or code.

Medicare Regulations
CP, Chapter 12, Section 30.5 (F)

- Chemotherapy Administration (or Non-chemotherapy Injection and Infusion) and Evaluation and Management Services Furnished on the Same Day.
  - For services furnished on or after January 1, 2004, do not allow payment for CPT code 99211, with or without modifier 25, if it is billed with a non-chemotherapy drug infusion code or a chemotherapy administration code. Apply this policy to code 99211 when it is billed with a diagnostic or therapeutic injection code on or after January 1, 2005.
  - Physicians providing a chemotherapy administration service or a non-chemotherapy drug infusion service and evaluation and management services, other than CPT code 99211, on the same day must bill in accordance with §30.6.6 using modifier 25.
  - ***The carriers pay for evaluation and management services provided on the same day as the chemotherapy administration services or a non-chemotherapy injection or infusion service if the evaluation and management service meets the requirements of section §30.6.6 even though the underlying codes do not have global periods***. If a chemotherapy service and a significant separately identifiable evaluation and management service are provided on the same day, a different diagnosis is not required.

Drug Administration Coding

A systematic approach

- What is the initial procedure?
- What kind of drug did we give them (Chemotherapy or supportive care)?
- How did we give it?
- How long did it take?

- These principals govern both hospital and physician coding for drug administration…but there are differences

A Building Block Approach to Office Coding

A systematic approach for offices

- Why was the patient here in the office?
- What did we give them?
- How did we give it?
- How long did it take?

“Initial” Group Once per Encounter

- Each group has at least one initial service code:
  - Initial Chemotherapy infusion 96413 (16 min up to 90 mins)
  - Initial Chemotherapy injection 96409 (≤ 15 minutes)
  - Initial Therapeutic Infusion 96365 (16 min up to 90 min)
  - Initial Therapeutic Push 96374 (≤ 15 minutes)
  - Initial Hydration 96360 (31 min up to 90 min)

*Initial or first hour of infusion (therapeutic infusions) is from 16 to 90 minutes

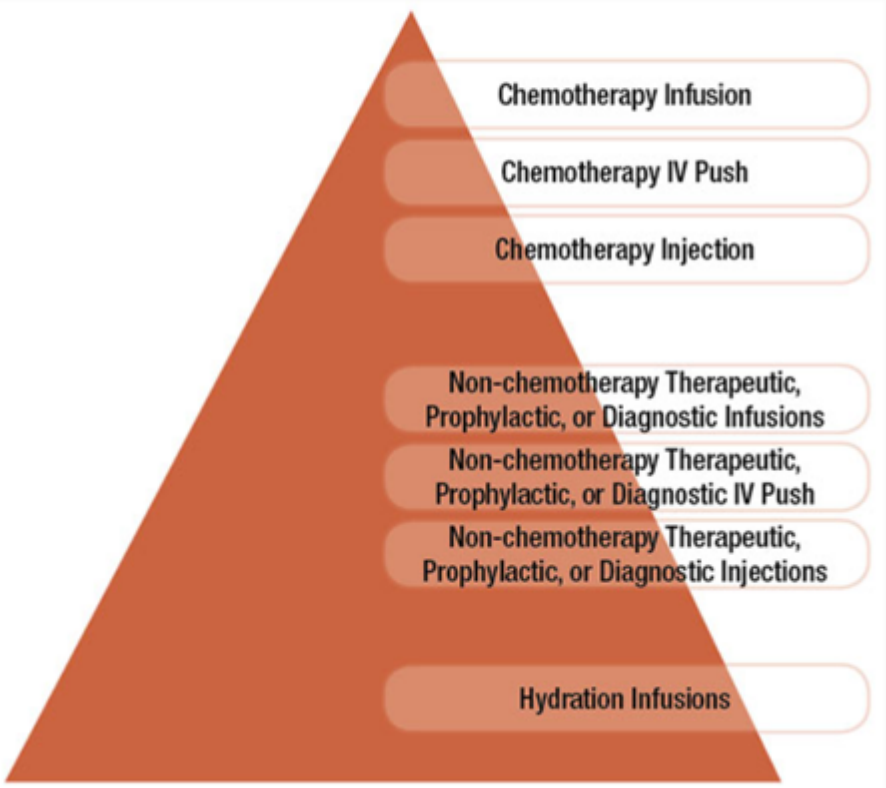
“Additional Service w/ New Substance” Group

- Additional infusions/injection of a new substance will be coded with sequential (or concurrent)codes:
  - sequential chemotherapy infusion 96417 (16 min up to 90 min)
  - sequential chemotherapy injection 96411 (≤ 15 minutes)
  - sequential therapeutic infusion 96367(16 min up to 90 min)
  - sequential therapeutic push 96375 ((≤ 15 minutes)
  - sequential hydration 96361 (31 min up to 90 min)

Hospital Hierarchy in Pictures

Figure 1 – Injection and Infusion Hierarchy for Facility Reporting

Figure 1 depicts the hierarchy rules associated with facility reporting of the initial injection or infusion service. If a patient receives two or more of these services, the service that is higher on the pyramid is reported as the initial service. For example, if the patient is receiving a chemotherapy injection and a hydration infusion, the chemotherapy injection is reported as the initial service, followed by the hydration infusion. The hierarchy takes precedence over parenthetical instructions for add-on codes. Keep in mind that this hierarchy applies to facility reporting, not to physician reporting.



What did we give them?

- Separate hydration over 30 minutes?
- Anti-emetics or other drugs?
- Chemotherapy?
- This determines which category of administration code(s) to bill
- And don’t forget to bill for the J-codes

How did we give it?

- IV infusion?
- IV push?
- SC or IM injection?
- A combination?

- This determines which specific administration code(s) to bill and if there are concurrent, subsequent, and/or sequential services.

How long did it take?

A push = Any infusion that is ≤ 15 minutes

First hour = Actually 16-90 minutes

Additional “hours”

Round to nearest 30 minutes

Same or different substance?

Different? Time starts over, not additive

Substances in one bag is a single infusion

Remember that infusion times are measured by when the infusate is actually running; pre- and post-infusion times are not included

Documentation of start/stop times crucial!

Hospitals Cannot Get Paid By Medicare for:

96368 for a Concurrent Infusions

- This code is used for infusions of non-chemotherapy drugs given at the same time as other drugs in separate bags
- It can be billed only once per day regardless of the number of concurrent drugs or hours
- For example. Intravenous fluorouracil was given over 2 hours with a concurrent infusion of leucovorin. An office would get paid for the leucovorin infusion; the hospital would not.

Subcutaneous or IM injections (96372, 96401) the same day as an infusion or push.

What Is The Charge Description Master?

- Sometime known as the “Chargemaster”, the Charge Description Master is the the list of codes by revenue department that are used for computerized charge entry
  - Offices have a similar list, but a limited number of people have input into the list (“Superbill”)
  - This is not true in the hospital setting where dozens of departments interact with the list daily
  - Because drug codes change each quarter, the CDM must be updated quarterly and have a comprehensive review once per year

Hospital Denials & Appeals

- Denials for claims are recorded on incoming remittance advice.
- Denials may be seen in Patient Accounting; but, may not be forwarded to the clinical area for months.
  - Inpatient denials are so much more expensive that outpatient denials can be a secondary concern.
  - Sometimes they are not addressed, until the problem is repetitive.
- Who addresses denials and appeals varies by institution
  - Patient Financial Services
  - Clinical Committees
  - Clinical Department
  - Pharmacy
- May pursue clinical information and/or drug replacement, if the $$ are significant

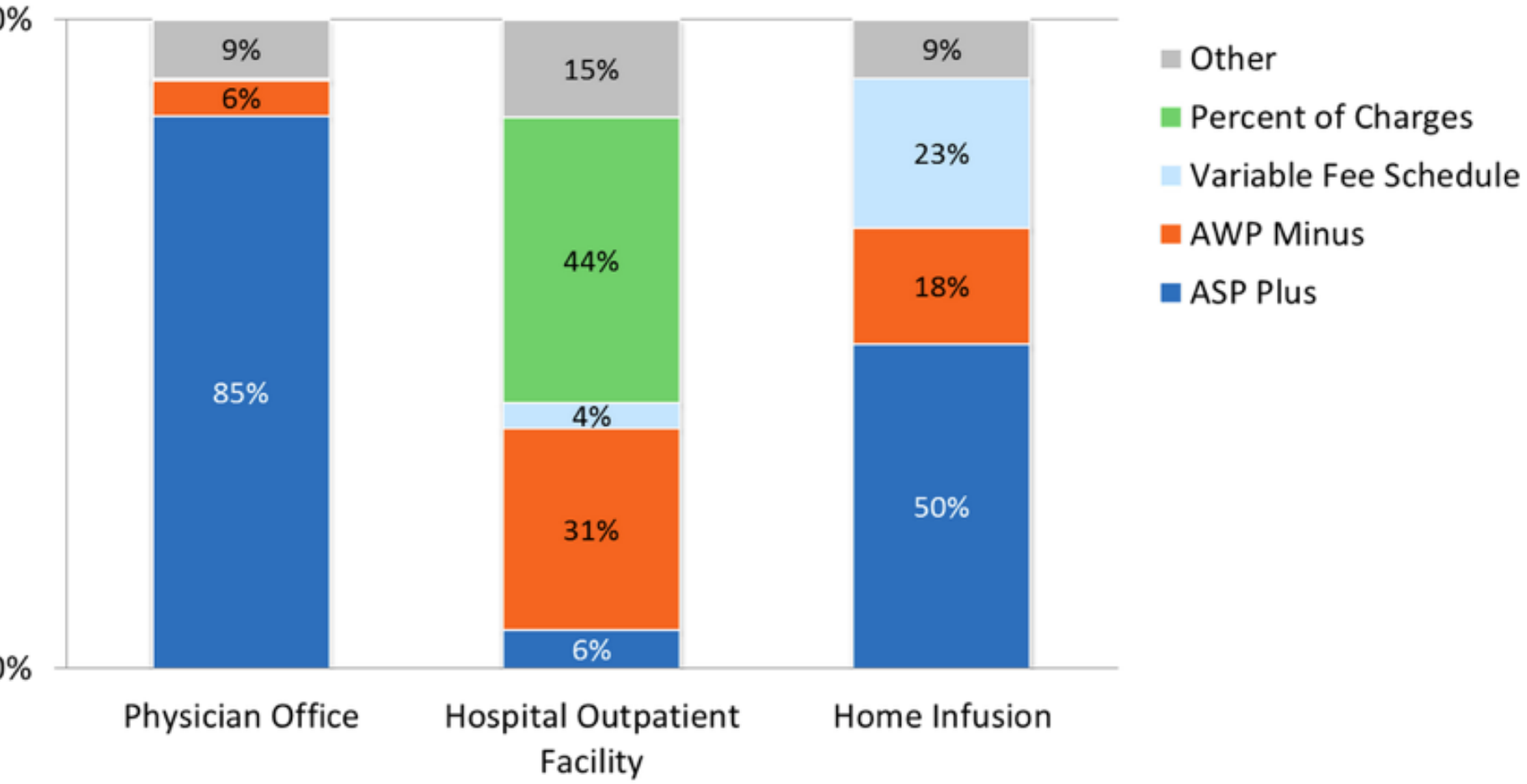
Drug Reimbursement

Hospital Versus Office

Types of Reimbursement for Drugs ("Buy and Bill")

- Percentage of Charges or Charge Ratio = A percent of what the provider charges and this is sometimes compared to cost
- Average Wholesale Price ("AWP") = The wholesale price set by the manufacturer
- Wholesale Acquisition Cost ("WAC") = The wholesale price minus 20% for many manufacturers of therapeutic drugs, including Genentech
- Average Sales Price ("ASP") = Average sales price which is calculated by a CMS intermediary as a weighted average for all NDCs in a specific drug HCPCS code
- Most Favored Nation Pricing ("MFN")—More about this later
- Capitation = A per member per month payment from an insurance company or employer. Some or all drugs may be paid separately ("carved out") or not ("carved in")
- Bundled = Payments where other drugs or services are bundled into the drug payment.

eimbursement Method for Drugs Paid Under the Medical Benefit, y Site of Care, 2014



AWP = Average Wholesale Price
ASP = Average Sales Price
Source: Pembroke Consulting analysis of *Magellan Rx Management 2014 Medical Pharmacy Trend Report*, March 2015.

Published on Drug Channels (www.DrugChannels.net) on March 26, 2015.

Medicare Payment Through The Drug Product Lifecycle General Rules

	Hospital Outpatient Drugs	Codes Used*	Physician Office	Code Used
First 1-3 Months	95% of AWP or WAC -22.5% for 340B hospitals or .846 of AWP or not at all	C9399 plus NDC	Invoice price or published price, if available to contractors	J9999 J3590 J3490 plus NDC
Next 4-6 months	WAC plus 3%	Specific C-code or Q-code or J-code	Invoice price or published price, if available to contractors on the NOC List (WAC plus 3% or ASP plus 6%)	J9999 J3590 J3490 plus NDC OR Specific Q-code Specific J-code
Next 7-24+ months	ASP plus 6%	J-code or C-code or Q-code	ASP plus 6%	Miscellaneous codes above or J-code or Q-code
24+ months	ASP plus 6% or non-passthrough bundled if ≤ $130 per day or ASP-22.5% for 340B drugs OR MFN Price	J-code or Q-code	ASP plus 6% OR MFN Price	J-code or Q-code

Commercial and Medicaid Payment Through The Drug Product Lifecycle General Rules

	Hospital Outpatient Drugs	Codes Used*	Physician Office	Code Used
First 1-3 Months	Invoice Multiple of AWP Multiple of WAC Multiple of ASP	C9399 NDC J9999 J3590 J3490	Invoice Multiple of AWP Multiple of WAC Multiple of ASP	J9999 J3590 J3490 plus NDC
Next 4-6 months	Multiple of AWP Multiple of WAC Multiple of ASP	Specific C-code or Q-code	Multiple of AWP Multiple of WAC Multiple of ASP	J9999 J3590 J3490 plus NDC Specific Q-code Specific J-code
Next 7-24+ months	Multiple of AWP Multiple of WAC Multiple of ASP	J-code or C-code or Q-code	Multiple of AWP Multiple of WAC Multiple of ASP	Miscellaneous codes above or J-code or Q-code
24+ months	Multiple of AWP Multiple of WAC Multiple of ASP	J-code or Q-code	Multiple of AWP Multiple of WAC Multiple of ASP	J-code or Q-code

Reporting J-code Drugs

Reporting Drug Dosage

Drugs are billed in multiples of the dosage specified in the HCPCS code long descriptor. If the drug dose used in the care of a patient is not a multiple of the HCPCS code dosage descriptor, the provider rounds to the next highest unit based on the HCPCS long descriptor for the code in order to report the dose provided.

When dosage amount in mg is greater than amount indicated for HCPCS code and no drug is wasted

-

Round up to determine units
Coding example–calculating units
HCPCS code: J0000
Drug: XYZ drug
Drug narrative dosage: 2 mg

Actual dose administered to patient: 5 mg with no waste
Report on Medicare claim:
HCPCS code: J0000
Units: three–5 mg divided by 2 mg = 2.5 units (round up to 3)

Medical Necessity

- **Medicare will pay for drug waste of single use items that are medically necessary and wastage appropriately documented in the record.**

➢ **LCD: Drugs and Biologicals, Non-Chemotherapeutic – 4I-81AB-R21**

➢ http://www.trailblazerhealth.com/Tools/LCDs.aspx?DomainID=1

Billing With - JW

- Effective January 3, 2017, all Medicare drug claims for single dose vials (SDVs) must reflect the amount of drug wasted:
  - Two lines—one for the drug used; the other for the amount wasted with Modifier –JW
  - Exception: when the J-code unit exceeds the amount given plus wastage
  - Wastage must be documented in the record with time, date, amount given, and amount wasted
  - Every effort should be made to minimize wastage

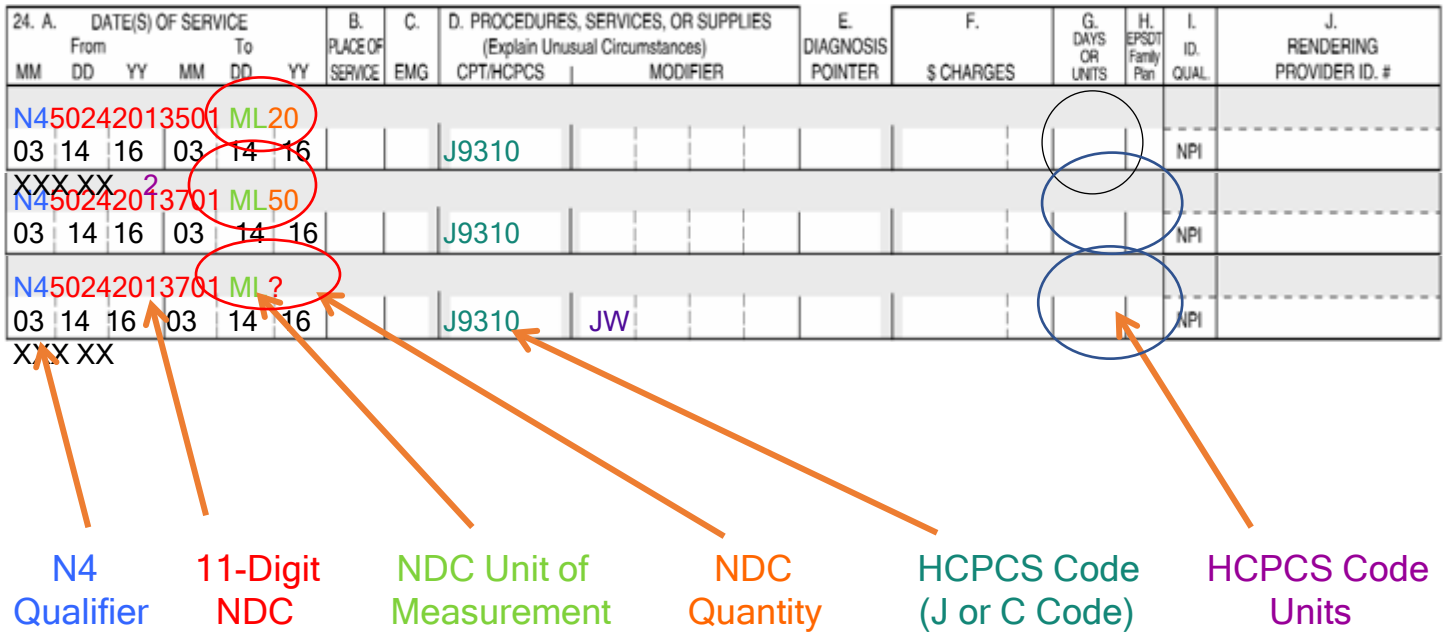
National Drug Codes

- Increasingly, payers are requiring National Drug Codes including
  - All Medicaid's
  - United
  - CIGNA
  - Some Blue plans
- In our proprietary database, 91% of 2019 claims had NDCs

Billing Waste on a CMS-1500

Billing Rituxan 680 mg dose with 20mg waste and JW Modifier

100 mg/10 ml and 500 mg/50 ml



N4 Qualifier

11-Digit NDC

NDC Unit of Measurement

NDC Quantity

HCPCS Code (J or C Code)

HCPCS Code Units

Entry of Correct NDC Numbers

- Each NDC must be reported as an eleven digit number based on the 5-4-2 principal without these dashes that we demonstrate below:

10-digit format on pkg	10-digit format by example	11-digit format	11-digit example
4-4-2	9999-9999-99	5-4-2	09999-9999-99
5-3-2	99999-999-99	5-4-2	99999-0999-99
5-4-1	99999-9999-9	5-4-2	99999-9999-09

Miscellaneous J-codes: Which to Use???

C9399--This is used for a very brief period of time before assignment of a HCPCS code in the Hospital Outpatient department.

J3490—This is used for non-cancer, non-biologic drugs before they have a J- or Q-code

J3590—This is used for biological drugs by SOME payers; it can also be used for biosimilars before their Q-code assignment

J9999—This is used for anti-neoplastic drugs prior to J-code assignment

Pre-Billing for Miscellaneous J-codes

- Package Insert
- NDC—For example, 76075-0101-01
- Pricing information
- Payer guidelines obtained from your biggest payers
- Package insert
- Information on cost and dating from distributor

C-codes (hardly needed) and Pass-through Status for Hospital Outpatients

- CMS must receive applications sufficiently in advance of the first calendar quarter in which transitional pass-through status is sought to allow time for analysis, decision making, and computer programming.
- The C-code application and pass-through status are entwined. In order to get pass-through status or a HCPCS code, submit the same application before these deadlines:

CMS must have a complete application and all necessary information by the first business date in:	Earliest possible date for pass-through status to be effective:
March	July 1
June	October 1
September	January 1
December	April 1

Outpatient Status Codes: Increased Importance

Status E = Payment not provided (E2 = Not paid due to lack of data or pricing information)

Status G = Pass-through Drugs and Biologics

Status K = Paid under OPPS; Non-Pass-Through Drugs, Biologicals

Status N = Items and Services Packaged into APC Rates

Billing for Miscellaneous Codes

- Generally…there are two types of billing
  1. All information in Box 19 or electronically in the 2400/SV101-7 loop
     - Units may be “1” for Medicare, but will vary for private insurers
     - Some want NDC
     - Some want dose in 24G; some in Box 19/ 2400
  2. NDC information in NDC loop electronically along with J-code billing

General Billing Guidelines for J9999 & J3590/J3490: Medicare

- Create billing code in practice management system or Charge Description Master for new “not otherwise classified” drug at smallest billing unit value (example 1 mg).
- Post new drug code charge at a multiple of the billing unit to equal patient’s dose. Remember to use modifier JW for wasted drug, where this is required by Medicare
- Attached to the line item drug charge, enter the following information in the 2400/SV101-7 for electronic claims or Box 19 on CMS-1500 paper claims or 2300 loop in CMS-1450, FL 80 of CMS 1450:
    - Drug Name
    - NDC Number
    - Total dose given
    - Total vials or amount wasted (if –JW is used)
    - Method of administration

What does this focalPoint data tell us?

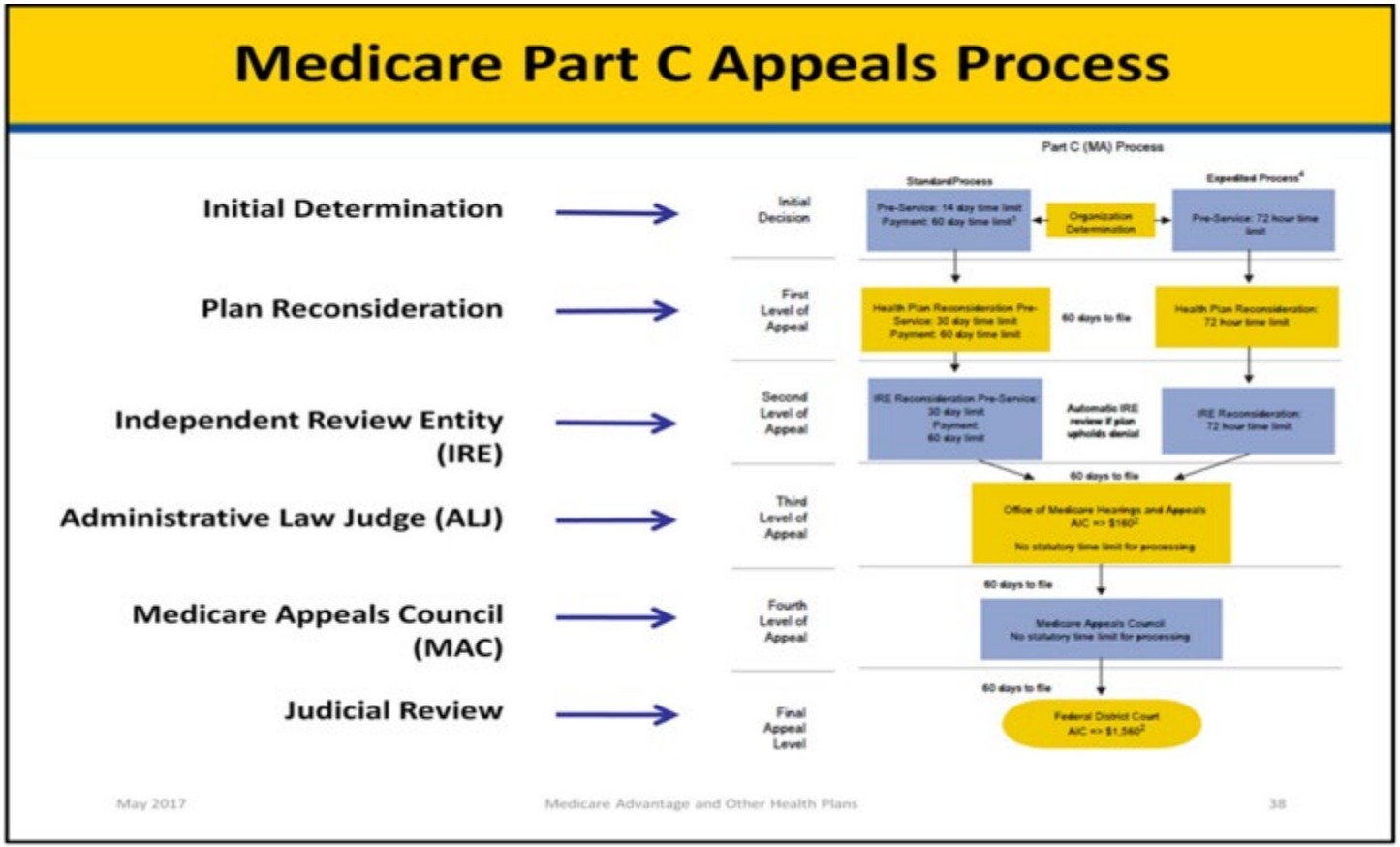
- At the end of the miscellaneous J-code period, denials and Days To Pay start to normalize EVEN without J-codes or Q-codes. Can you normalize your denial rate before a code comes out? (May be a moot point)
  - Make sure all applications are in ASAP.
  - Make sure the 5-4-2 format for NDCs is on every claim.
  - Ensure you know the miscellaneous code policies of the 20% of payers that account for 80% of a customer's claims
  - Submit pricing information. Check "BuyandBill. com"
  - For all drugs, match what was submitted for prior auth with what is billed for claims of all ages

Problems With No HCPCS

- Different requirements for different payers, even among MACs
- Pricing, pricing, pricing
- NDC in the NDC “loop” or Box 19 (Miscellaneous place)
- Delays in Outpatient Payment due to new code process
- HCPCS approval process somewhat arbitrary.

Appendix: MA and Part D Appeals

Medicare Advantage Appeals



Medicare Advantage Appeals

- "Organization determination" is initial determination regarding basic and optional benefits
  - Can be provided before or after services received
  - Issued within 14 days
- May request expedited organization determination if delay could jeopardize life/health or ability to regain maximum function.
  - Plan must treat as expedited if requested by doctor
  - Issued within 72 hours

Medicare Advantage (MA)

- Request reconsideration w/i 60 days of notice of the organization determination
- Reconsideration decision issued within
  - 30 days for standard reconsideration
  - 72 hours for expedited reconsideration
- Unfavorable reconsiderations automatically referred to independent review entity (IRE)
  - Time frame for decision set by contract, not regulation
- Unfavorable IRE decisions may be appealed
  - to ALJ
  - to MAC
  - to Federal Court

Medicare Advantage (MA)

- Fast-Track Appeals to Independent Review Entity (IRE) before services end for
  - Terminations of home health, SNF, CORF
  - Two-day advance notice
  - Request review by noon of day after notice received
  - IRE issues decision by noon of day after day it receives appeal request
- 60 days to request reconsideration by IRE
  - 14 days for IRE to act

Part D Appeals Process - Overview

- Each drug plan must have an appeals process
  - Including process for expedited requests
- A coverage determination is first step to get into the appeals process
  - Issued by the drug plan
  - An "exception" is a type of coverage determination
- Next steps include
  - Redetermination by the drug plan
  - Reconsideration by the independent review entity (IRE)
  - Administrative law judge (ALJ) hearing
  - Medicare Appeals Council (MAC) review
  - Federal court

Part D Appeals Process – Coverage Determination

- A coverage determination may be requested by
  - A beneficiary
  - A beneficiary's appointed representative
  - Prescribing physician
- Drug plan must issue coverage determination as expeditiously as enrollee's health requires, but no later than
  - 72 hours standard request
    - Including when beneficiary already paid for drug
  - 24 hours if expedited- standard time frame jeopardize life/health of beneficiary or ability to regain maximum function.

Exceptions: A Subset Of Coverage Determination

- An exception is a type of coverage determination and gets enrollee into the appeals process
- Beneficiaries may request an exception
  - To cover non-formulary drugs
  - To waive utilization management requirements
  - To reduce cost sharing for formulary drug/ tiering appeal
    - No exception for specialty drugs or to reduce costs to tier for generic drugs
- A doctor must submit a statement in support of the exception

Part D Appeals - Coverage Determinations Are Not Automatic

- A statement by the pharmacy (not by the Plan) that the Plan will not cover a requested drug is not a coverage determination
  - Enrollee who wants to appeal must contact drug plan to get a coverage determination
  - Drug plan must arrange with network pharmacies
    - To post generic notice telling enrollees to contact plan if they disagree with information provided by pharmacist or
    - To distribute generic notice

Part D Appeals Process - Next Steps

- If a coverage determination is unfavorable:
  - Redetermination by the drug plan.
    - Beneficiary has 60 days to file written request (plan may accept oral requests).
    - Plan must act within 7 days - standard
    - Plan must act within 72 hrs.- expedited
  - Then, Reconsideration by IRE
    - Beneficiary has 60 days to file written request
    - IRE must act w/i 7 days standard, 72 hrs. expedited
  - ALJ hearing
  - MAC review
  - Federal court

Part D Grievance Process

- Each drug plan must have a separate grievance process to address issues that are not appeals
- May be filed orally/in writing within 60 days
- Plans must resolve grievances
  - w/i 30 days generally
  - w/i 24 hrs if arise from decision not to expedite coverage determination or redetermination