Oncology Reimbursement Toolbox

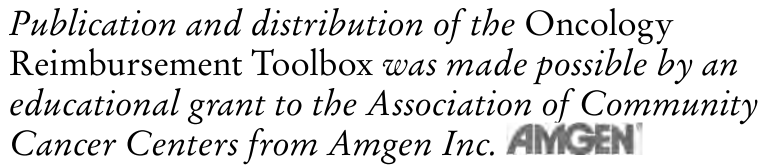
A WORKBOOK FOR CANCER CENTERS

2007

The Center for Provider Education ACCC

ACCC Association of Community Cancer Centers

Publication and distribution of the Oncology Reimbursement Toolbox *was made possible by an educational grant to the Association of Community Cancer Centers from Amgen Inc.*



Material in this publication was provided by:
The Pritchard Group, LLC
520 Longhorn Crescent
Rockville, MD 20850
240.478.7800
www.thepritchardgroup.net

Although we have exerted every effort to ensure that the information presented is complete and accurate at the time of publication, there is no guarantee that this information will remain current over time as reimbursement policy is constantly changing. Neither ACCC nor The Pritchard Group, LLC, shall be liable or responsible for any loss, injury, or damage allegedly arising from any information in this book.

Cover photograph: © Karen Capucilli/Graphistock

© Association of Community Cancer Centers 2007
All rights reserved.

Oncology Reimbursement Toolbox

Association of Community Cancer Centers

Contents

Preface 3

Introduction: A Team Approach to Navigating APCs 5
- Charge Preparation
- Capturing Charges
- The Billing Process

Chapter 1: Charge Preparation 7
- Know Your Charges, Revenue, and Expenses
- Keep Up with Coding and Billing Changes
- Develop a Chargemaster
- The Impact of Not Charging Correctly
- Understand Your Managed Care Contract

Chapter 2: Charge Capture 14
- Schedule and Register Patients
- Verify Insurance Coverage
- Pre-authorize Treatment
- Collect Deductibles, Co-payments, and Co-insurance
- Use Encounter Forms
- Assure Charge Capture Quality
- Use Modifers Correctly
- Verify and Update Diagnosis Codes
- Educate and Keep Close Tabs on the Pharmacy
- Reconcile Charges

Chapter 3: Claims Production 19
- Scrub Claims
- Generate Error Reports
- Print Claims
- Submit Claims

Chapter 4: Payment Processing 21
- Post Payments
- Review EOBs at Posting
- Be Proactive with Suspended or Denied Claims
- Review Denied Claims and Follow Up
- File Secondary Claims
- Recognize Department Revenue
- Have Accounts Receivable Follow Up

Chapter 5: Medical Oncology 2007 23
- Reimbursement Outlook
- Infusion Services
  - Administration Codes
  - Clinic Visits
  - Blood and Blood Products
- Drugs, Biologicals, and Radiopharmaceuticals
  - Understanding Average Sales Price (ASP)
  - Transitional Pass-Through Payment for Additional Costs of Drugs and Biologicals
  - Intravenous Immunoglobulin (IVIG)
- Reduction in Threshold for Separate APCs for Drugs
  - Packaged Drug Costs
  - Anti-emetics

Chapter 6: Radiation Oncology and Oncology Imaging 2007 28
- Reimbursement Outlook
- Brachytherapy
- Breast Brachytherapy
- Stereotactic Radiosurgery
- Intensity Modulated Radiation Therapy
  - Hospital Coding and Billing for IMRT
  - Hospital Coding and Billing for Compensator-based IMRT
  - Documentation Requirements for IMRT
- Imaging Reimbursement for 2007
- Positron Emission Tomography (PET) Scans and PET/CT
- Whole Body Tumor Imaging
- Colorectal Cancer Screening

Appendix I – Policies 34
- Insurance Verification Policy
- Treatment Pre-authorization Policy
- Charge Capture Policy
- Claims Billing Policy
- Insurance Denial and Follow-up Policy

Appendix II – Forms 40
- Encounter Forms
  - Medical Oncology
  - Radiation Oncology

The Center for Provider Education of the Association of Community Cancer Centers (ACCC) is pleased to present this publication as part of The Cancer Program Improvement Project, which is designed to provide cancer programs with the innovative tools they need to solve management problems and ensure financial viability. Publication and distribution of this toolbox is supported by an educational grant from Amgen Inc. A training workshop also offered by ACCC and supported by an educational grant from Amgen Inc. provides insights into how to implement the items in this toolbox.

This booklet is designed to help the Cancer Center Administrator improve financial results and thereby create and maintain the best cancer program possible. All materials in this publication are compliant with Medicare regulations issued by the Centers for Medicare & Medicaid Services (CMS) and the Health Insurance Portability and Accountability Act (HIPAA) as of Jan. 1, 2007. These rules are amended on a regular basis, so you must keep abreast of changes. To do so, we recommend that you visit the CMS website, *www.cms.hhs.gov*. Additionally, you should monitor the local Fiscal Intermediary (FI) or Medicare Administrative Contractors (MACs) interpretations of CMS rules through the Local Medical Review Policy (LMRP), if any, which are published on the FI's or MAC's websites as well as staying up to date with local coverage determination (LCD) rules.

The many changes in rules and regulations that have impacted outpatient payment have created the critical need for hospital administrative leaders to evaluate their oncology product line. It is imperative that hospitals poise themselves to operate effectively and efficiently and, more importantly, to plan the strategic direction for their oncology program.

To succeed under ambulatory payment classifications (APCs), hospitals must change their internal operations and adopt a team approach to managing outpatient oncology services. This booklet will provide suggestions to help Patient Accounts work more closely with other departments that provide services.

Also included in this booklet is a detailed explanation of the hospital outpatient revenue generation process for cancer services, including medical oncology, radiation oncology, and pharmacy. Additionally, we have provided policies, procedures, and forms as examples. Although there are many ways to implement these procedures, quality assurance is as important as the actual policy itself.

The process described includes four actual phases: charge preparation, charge capture, claims production, and payment processing. Each phase necessitates working cooperatively with other departments within your hospital. ◆

HOPPS In Brief

The Hospital Outpatient Prospective Payment System (HOPPS) 2007 final rule was posted to the CMS website on November 24, 2006. All policies and payment rates were effective January 1, 2007.

For 2007 the conversion factor update is equal to the hospital inpatient market basket, which is at 3.4 percent. CMS adjusted the conversion factor by the adjustment of 0.04 percent for the difference in pass-through set-aside, the rural payment adjustment for rural sole community hospitals (SCHs) of 0.99997 percent, and the wage index budget neutrality adjustment of approximately 0.9993. The 2007 conversion factor is $61.468, a 3.29 percent increase from the CY 2006 conversion factor of $59.511.

One intent of the HOPPS rule was to reduce patient co-insurance payment over time to 20 percent of the payment for each procedure. In 2007 the maximum co-payment allowed is 40 percent. All new codes are introduced with lower co-payments. Addendums A and B of the Final Rule identify co-payment by procedure code. ◆

A Team Approach to Navigating APCs

Managing hospital outpatient oncology services requires a team with members from several hospital departments. That team should include the individuals responsible for chargemasters and those responsible for setting charges, the individual who understands all the managed care and insurance contractual rules and agreements, and the Chief Financial Officer. The team also includes the Patient Accounts Director, Information Services Director, Medical Information Manager, Pharmacy Director, Medical Oncology and/or Infusion Center Manager(s), Diagnostic Imaging Manager, Laboratory Manager, Oncology Inpatient Manager, Radiation Oncology Manager, and Admissions Director or person responsible for patient demographics.

The Cancer Center Administrator, who is responsible for the product line, leads the team. He or she must know how each department works. Moreover, this individual must understand what each department does to impact the cancer center's ability to determine and capture charges and send appropriate bills out the door.

Today, Medicare annually recalibrates costs for oncology services. Costs must reflect the service as defined by Medicare. If we prepare charges that have an accurate relationship to costs, we have an opportunity for Medicare to recognize the *real* costs to hospitals for oncology services. If we are ever to see appropriate reimbursement under the ambulatory payment classification (APC) payment system, charges must have an accurate relationship to costs.

Charge Preparation

Since charges are built around costs, every charge should adequately represent the cost of the service and exist in relationship to other services' charges and costs. Under APCs, the relationship between charges and costs is critical to receiving the reimbursement to which an institution is entitled. Unfortunately, all too often the Finance and Managed Care department staffs do not understand what is involved in delivering individual oncology services. In addition, they probably do not know which services are separate and distinct or which are an integral part of another. Without detailed knowledge about services, cost data, managed care contract information, and an understanding of the systems that produce the claims, chargemasters cannot be accurately built.

Finance traditionally prepares the systems necessary to assure payment, and the Managed Care team augments the work of Finance. Together these departments must assure that the rules established by each patient's insurer are built into the hospital billing systems so that a clean claim is produced. To be paid promptly, every claim must be exact.

Capturing Charges

In addition to Oncology Services, at least four other departments should be involved in the charge capture phase: Medical Records, Patient Accounts, Pharmacy, and Information Systems.

Patient Accounts and Oncology Services must work together in the charge capture phase because of a peculiar problem regarding diagnosis coding on claims. Because oncology is required to use a high number of series or recurring accounts, new medical diagnoses are frequently recorded in the chart but *not* added to the claim. Yet, to receive payment for provided services, *all* diagnosis codes must be on the patient claim. Many institutions have not developed any mechanisms to add diagnoses to patients' bills. Capturing the service is not enough.

Patient Accounts must also work with Pharmacy and Information Services to assure that all drug charges are accurately captured. Usually, drug charges are sent directly from the pharmacy to Patient Accounts at the end of every day through an interface between the pharmacy and claims systems. However, the pharmacy system is clinical and was never designed to provide billing services. Too often,

the interface between Pharmacy and Patient Accounts is inadequate and does not capture updated drug pricing, actual costs, or billing system changes.

The Billing Process: Claims Production and Payment Processing

The billing process also requires teamwork among departments, particularly cooperation between Patient Accounts and service departments. Before claims are submitted for payment, they are sent through an internal editing system that checks for correct coding and other medical necessity edits. If a claim doesn't pass, it will be reviewed by the Patient Accounts Department, which may need additional information from the service department. Patient Accounts also produces an error report that identifies submitted billing information that is incomplete or incorrect. The only way these claims can be corrected is by the service department.

Once claims have been adjudicated, Patient Accounts must work with the service departments to determine which denied claims or services should be appealed or corrected for payment. Denied claims must have supporting documentation, and no appeal should be made without first evaluating that documentation. The service line manager is capable of evaluating the documentation and has access to it as well. Patient Accounts with Compliance can initiate the appeals process.

In the near future, quality measurements and increased detailed compliance of quality assurance will be embedded in the claims reporting. You must begin to assure that your basic systems are in place and working properly now. Waiting for pay for performance (P4P) to be the norm before you make changes will be too late. ◆

Charge Preparation

Know Your Charges, Revenue, and Expenses

The first rule in Charge Preparation is to know your charges, revenue, and expenses. Make sure your charges cover your costs. Know what is billable. Then, either bundle everything to those codes or bill every item to show cost, even those for which you expect no payment. Make certain that you include all direct and indirect costs. Use a benchmark of local charges to ensure that you capture the market rate.

Next, properly record all revenue. Know what the rules are and learn what patient accounts, medical records, finance, and information services departments are doing to help you submit clean and appropriate bills to insurers. Is the data interface working optimally between billing and radiation and pharmacy clinical services? Are proper ICD-9-CM codes being added? Are modifiers being used properly? Most of all, act like an independent business. Track trends and make projections. Identify potential problems and solve them before they cause trouble.

Keep Up with Coding and Billing Changes

Every cancer center should have a task force that evaluates the impact of rule and coding changes and alerts senior administration to potential threats to the program. This task force should include the Medical and Radiation Oncology Managers, the Pharmacy Manager, Compliance, and the Patient Accounts Manager at the very least. Stay current. Use the CMS web site to get timely information: *www.cms.hhs.gov*.

Chapters in this toolbox detail 2007 medical and radiation oncology reimbursement and coding changes under the Medicare Prescription Drug, Improvement and Modernization Act (MMA). In brief, overall reimbursement in 2007 for hospital outpatient medical and radiation oncology services have increased slightly.

Develop a Chargemaster

When developing a chargemaster, you want to make sure that you recognize all of the services you provide. Typically an Oncology Department has between 35 and 50 different services (not including drugs) that it can bill. The chargemaster should be reviewed yearly for coding changes and charge updates.

An ideal chargemaster is prepared with the following: (See pages 10-13.)

- APC/CPT descriptions—Narrative descriptions of the service provided
- Revenue codes associated with the service
- HCPCS and CPT codes associated with the service
- Current charges
- Charges at the 50th percentile
- Charges at the 75th percentile

When determining a charge, know your costs and decide where you want to position yourself within your region. Remember, CMS looks at payment for drugs and services differently than other payers.

Building a chargemaster cannot be accomplished in a financial vacuum. Each service department must understand the new rules, have guidance from the Compliance and Managed Care departments, and then build a chargemaster with the Finance department that makes every service or procedure billable. Each service department must also work with Information Services and Patient Accounts to build encounter screens that make clinical sense so that data entry is accurate and complete.

To make sure your chargemaster is perfect, check charges, revenue codes, descriptions, and HCPCS codes. Revenue and HCPCS code requirements may be different for different payers, so make certain all are correctly loaded for claims processing. Only one charge description needs to show on chargemaster or data entry screens.

Tips

- It is better to start from scratch than to try to adapt an old chargemaster for APCs.
- Building efficient oncology chargemasters requires a specialist in oncology billing.

Tips

- Make certain you include all direct and indirect costs.
- ...have a task force that evaluates the impact of rule and coding changes and alerts senior administration to potential threats to the program.
- ...check charges, revenue codes, descriptions, and HCPCS codes.
- Use your strengths, economies of scale, market share, positioning in the market, and any special services you perform to influence the carrier to accept a better contract.
- Know your costs and never agree to accept less for services than the cost to provide.

The Impact of Not Charging Correctly

Too many hospitals do not identify their charges. Since understanding the charges is the foundation of accurate charge capture, this creates incorrect reporting and results in lowered payment. When hospitals report inaccurate or incomplete charges to Medicare, these data directly influence Medicare reimbursement, in our case, for chemotherapy administration and radiation therapy. Providers continue to face cost-to-charge (CCR) issues in infusion administration because of under-reporting of supply and diluent usage.

The costs of drugs less than $150 were bundled into these reimbursements for 2003, and the bundled drug payments were reduced to $50 for 2004 and that continued for 2005 and 2006. This year CMS has raised the threshold to account for medical inflation. The new bundling threshold is $55. It will continue to rise with medical inflation in the future. (Details for the calculation can be found on the CMS website). A good part of these reimbursement reductions can be attributed to the fact that hospitals have not effectively set charges and reported their costs.

Hospitals must focus on coding correctly and for every service that they provide. CMS has begun to change its cost-to-charge data and means tests to create state-average CCRs. These state profiles may enable CMS to move towards a packaged payment for service based on rate setting more like diagnosis related groups (DRGs). While CMS has pointed out its plan to maintain a procedure-based system, its new technology additions are often more bundled to create ease in implementation of billing and to reduce potential high utilization of procedures in support of the new technique.

Finally, in 2008 CMS will require quality reporting for hospitals to receive full HOPPS payment. This additional risk to payment highlights the importance of preparing charges accurately based on efficient quality service provision.

Understand Your Managed Care Contract

The growth of managed care has altered payment methods to providers and put the provider at risk for services, a change that creates incentives for greater coordination of care and attention to outcomes. These changes produce two distinct responses by healthcare organizations:

- Build organizational arrangements and partnerships for contracting with managed care organizations
- Build internal systems to manage care and affect healthcare costs and medical practice.

Organizational innovation should be designed to gain greater leverage in contracting and economies of scale for resource management.

The basic rules for determining the value of any contract remain the same: Know your costs and never agree to accept less for services than they cost to provide. ◆

Know Your Costs

If your contract is paying less than your cost of $16.48 for the 99211, Level 1 visit, for example, you may not want that contract. The same applies to the chemotherapy by infusion example below.

HCPCS	Description	RVU
99211	Level 1 visit	.8242

1. CPT x Associated RVUs = 100,000
2. Last year's expenses = $200,000
3. $200,000 divided by 100,000 = Cost per RVU or $20
4. RVU value (.8242) times cost per RVU ($20) = $16.48

HCPCS	Description	RVU
96413	Chemotherapy by infusion, complex	2.4851

1. CPT x Associated RVUs = 50,000
2. Last year's expenses = $2,100,000
3. $2,100,000 divided by 50,000 = Cost per RVU or $42
4. RVU value (2.4851) times cost per RVU ($42) = $104.37

Other Tips

- Never sign a managed care contract without reading it. Often the contract is long and contains language that obligates you to conditions that are not favorable to your hospital.

- Make sure your drugs are not bundled into the payment. There are many high-cost drugs, and they need to be paid separately.

- Strike out any unacceptable terms and initial each strike. If the carrier does not accept these terms, negotiate for terms that are better than the original contract. Use your strengths, economies of scale, market share, positioning in the market, and any special services you perform to influence the carrier to accept a better contract.

- If you cannot live with the contract, do not accept it!

Chargemaster (CDM) for Medical Oncology Under Ambulatory Payment Classifications (APCs)*

APC Description	Rev Code	Relative Weight	HCPCS CPT	Current Charge**	50th %ile	75th %ile
Thoracentesis	280, 940 or 510	3.6244	32000		$309.96	$416.65
Blood transfusion service	390	3.4584	36430		$95.99	$137.66
Insertion of non-tunneled central venous catheter, under 5 years old	280, 940 or 510	8.7846	36555		$527.94	$757.15
Insertion of non-tunneled central venous catheter, ages 5 and older	280, 940 or 510	8.7846	36556		$461.95	$662.50
Insertion of tunneled central venous catheter, under 5 years old	280, 940 or 510	22.6665	36557		$1,559.84	$2,237.03
Insertion of tunneled central venous catheter, ages 5 and older	280, 940 or 510	22.6665	36558		$1,439.85	$2,064.95
Insertion of peripherally inserted central venous catheter, PICC, without subcutaneous port or pump, ages 5 and older	280, 940 or 510	8.7846	36569		$551.95	$791.56
Insertion of peripherally inserted central venous catheter, PICC, with subcutaneous port, ages 5 and older	280, 940 or 510	22.6665	36571		$2,519.74	$3,613.67
Bone marrow aspiration	305	2.4011	38220		$260.10	$358.77
Bone marrow biopsy	305	2.4011	38221		$280.91	$387.46
Abdominal paracentesis, initial	280, 940 or 510	3.6244	49080		$285.61	$375.86
Abdominal paracentesis, subsequent	280, 940 or 510	3.6244	49081		$223.89	$294.60
Aspiration of bladder by needle	280, 940 or 510	2.1392	51000		$297.03	$397.32
Aspiration of bladder by trocar or intracatheter	280, 940 or 510	1.0887	51005		$331.98	$444.06
Aspiration of bladder with insertion of suprapubic catheter	280, 940 or 510	18.1679	51010		$698.90	$934.86
Spinal puncture, lumbar	280, 940 or 510	2.2614	62270		$260.30	$325.53
Epidural injection, blood or clot patch	280, 940 or 510	5.7253	62273		$568.37	$710.80
Epidural injection, cervical or thoracic	280, 940 or 510	6.3603	62310		$626.02	$782.91
Epidural injection, lumbar	280, 940 or 510	6.3603	62311		$543.66	$679.90
Injection anesthesia, occipital nerve	280, 940 or 510	2.2614	64405		$350.57	$475.15
Injection anesthesia, intercostal nerve, single	280, 940, or 510	2.2614	64420		$623.24	$844.71
Injection anesthesia, cervical	280, 940 or 510	6.3603	64510		$1,188.06	$1,610.23
Therapeutic enema	320	1.4294	74283		$275.97	$326.28
Pentamidine, aerosol	460	1.1206	94642		$153.75	$203.50
Phlebotomy (therapeutic)	940	0.5723	99195		$62.97	$85.82
Level I visit, new patient	280, 510	0.8242	99201		None Available	
Level II visit, new patient	280, 510	0.9840	99202		None Available	
Level III visit, new patient	280, 510	1.3646	99203		None Available	
Level IV visit, new patient	280, 510	1.7096	99204		None Available	
Level V visit, new patient	280, 510	2.1794	99205		None Available	
Level I visit, established	280, 510	0.8242	99211		None Available	
Level II visit, established	280, 510	0.9840	99212		None Available	
Level III visit, established	280, 510	0.9840	99213		None Available	
Level IV visit, established	280, 510	1.3646	99214		None Available	
Level V visit, established	280, 510	1.7096	99215		None Available	
Consultation, Level I	280, 510	0.8242	99241		None Available	
Consultation, Level II	280, 510	0.9840	99242		None Available	
Consultation, Level III	280, 510	0.9840	99243		None Available	
Consultation, Level IV	280, 510	1.3646	99244		None Available	
Consultation, Level V	280, 510	1.7096	99245		None Available	
Critical Care E&M, first 30-74 mins	280, 333 or 510	6.5894	99291		None Available	
Critical Care E&M, each add'l 30 minutes	280, 333 or 510	_	99292		None Available	
Prolonged service, first hour	280, 510	_	99354		None Available	

APC Description	Rev Code	Relative Weight	HCPCS CPT	Current Charge**	50th %ile	75th %ile
Prolonged service, each add'l 30 minutes	280, 510	_	99355		None Available	
Routine venipuncture for collection of specimen	280, 510	_	36415		None Available	
Vaccine administration, influenza	771	0.3945	G0008		None Available	
Vaccine administration, pneumonia	771	0.3945	G0009		None Available	
Vaccine administration, hepatitis B	771	.	G0010		None Available	
Immunization administration, each add'l	771	0.1809	90472		$23.59	$31.70
Immunization administration, oral/nasal	771	0.1809	90473		$23.59	$31.70
Immunization administration, oral/nasal add'l	771	0.1809	90474		$23.59	$31.70
Interdisciplinary team conference	280, 510	2.1794	G0175		None Available	
Hydration intravenous infusion, initial	260	1.8090	90760		$124.65	$172.36
Hydration intravenous infusion, add-on	260	0.3945	90761		$39.36	$54.43
Therapeutic/prophylactic/diagnostic iv inf, initial	260	1.8090	90765		$153.07	$211.67
Therapeutic/prophylactic/diagnostic iv inf, add-on	260	0.3945	90766		$50.29	$69.55
Therapeutic/prophylactic/diagnostic add'l seq iv inf	260	0.3945	90767		$83.10	$114.90
Therapeutic/prophylactic/diagnostic concurrent inf	260	_	90768		$48.11	$66.53
Therapeutic/prophylactic/diagnostic inj, sq/im	260	0.3945	90772		$36.09	$49.89
Therapeutic/prophylactic/diagnostic inj, ia	260	0.7942	90773		$37.18	$51.41
Therapeutic/prophylactic/diagnostic inj, iv push	260	0.7942	90774		$113.71	$157.25
Therapeutic/prophylactic/diagnostic inj, add-on	260	0.7942	90775		$52.48	$72.57
Therapeutic/prophylactic/diagnostic inj/inf procedure	260	0.1809	90779		$23.59	$31.70
Chemotherapy, antineoplastic, sq/im	331, 332, or 335	0.7942	96401		$101.29	$133.74
Chemotherapy hormonal antineoplastic sq/im	331, 332, or 336	0.7942	96402		$55.25	$72.95
Chemotherapy intralesional, up to 7 lesions	331, 332, or 337	0.7942	96405		$193.36	$255.33
Chemotherapy intralesional, over 7 lesions	331, 332, or 338	0.7942	96406		$230.20	$303.97
Chemotherapy, iv push, single drug	331, 332, or 339	1.5848	96409		$187.23	$247.22
Chemotherapy, iv push, add'l drug	331, 332, or 340	1.5848	96411		$107.43	$141.86
Chemotherapy, iv infusion, 1 hour	331, 332, or 341	2.4851	96413		$270.10	$356.65
Chemotherapy, iv infusion, add'l hour	331, 332, or 342	0.7942	96415		$61.39	$81.06
Chemotherapy, prolonged infusion w/pump	331, 332, or 343	2.4851	96416		$288.52	$380.96
Chemotherapy, iv infusion, each add'l seq	331, 332, or 344	0.7942	96417		$128.91	$170.22
Chemotherapy, intra-arterial push technique	331, 332, or 345	1.5848	96420		$168.82	$222.91
Chemotherapy, intra-arterial infusion up to 1 hour	331, 332, or 346	2.4851	96422		$303.86	$401.23
Chemotherapy, intra-arterial infusion each add'l hour	331, 332, or 347	0.7942	96423		$122.77	$162.11
Chemotherapy, infusion, intra-arterial w/pump	331, 332, or 348	2.4851	96425		$276.24	$364.76
Chemotherapy, pleural cavity	331, 332, or 349	2.4851	96440		$552.47	$729.51
Chemotherapy, peritoneal cavity	331, 332, or 350	2.4851	96445		$537.13	$709.26
Chemotherapy, into central nervous system	331, 332, or 351	2.4851	96450		$491.09	$648.46
Refill/maintenance portable pump	331, 332, or 352	1.8090	96521		$236.34	$312.07
Refill/maintenance pump/reservoir system	331, 332, or 353	1.8090	96522		$171.88	$226.96
Irrigation drug delivery device	331, 332, or 354	0.5145	96523		$42.97	$56.74
Chemotherapy, injection	331, 332, or 355	0.7942	96542		$294.65	$389.08
Chemotherapy, unspecified	331, 332, or 356	0.1809	96549		None Available	
Prolonged intravenous infusion, regular pump	331, 332, or 357	2.4851	C8957		None Available	

* Unadjusted national numbers

** Technical charges only

Chargemaster (CDM) for Radiation Therapy Under Ambulatory Payment Classifications (APCs)*

APC Description	Rev Code	Relative Weight	HCPCS CPT	Current Charge**	50th %ile	75th %ile
Radiation therapy fields placement	333	1.5379	77014***		***	***
Echo guidance radiotherapy	940	1.1882	76950		$393.80	$547.46
Simulation, simple	333	1.5735	77280		$812.07	$1,074.04
Simulation, intermediate	333	3.9723	77285		$1,191.64	$1,576.07
Simulation, complex	333	3.9723	77290		$1,525.59	$2,017.75
Simulation 3-D	333	13.8081	77295		$1,919.76	$2,539.07
Basic dosimetry	333	1.5735	77300		$140.56	$186.03
IMRT treatment planning	333	13.8081	77301		$2,914.16	$3,857.12
Isodose plan, simple	333	1.5735	77305		$195.61	$258.77
Isodose plan, intermediate	333	3.9723	77310		$244.71	$323.68
Isodose plan, complex	333	3.9723	77315		$279.30	$280.08
Special teletherapy plan	333	3.9723	77321		$419.89	$555.61
Brachy isodose plan, simple	333	1.5735	77326		$247.64	$327.81
Brachy isodose plan, intermediate	333	3.9723	77327		$364.58	$482.61
Brachy isodose plan, complex	333	3.9723	77328		$513.79	$679.87
Special dosimetry	333	1.5735	77331		$51.58	$68.25
Continuing medical physics	333	1.5735	77336		$344.04	$455.23
Special physics consult	333	1.5735	77370		$364.89	$482.82
Radiation treatment, simple 4 MEV	333	1.4826	77402		$228.06	$301.76
Radiation treatment, simple 6-10 MEV	333	1.4826	77403		$228.06	$301.76
Radiation treatment, simple 11-19 MEV	333	1.4826	77404		$228.06	$301.76
Radiation treatment, simple 20 MEV	333	1.4826	77406		$228.06	$301.76
Radiation treament, intermediate 4 MEV	333	1.4826	77407		$293.22	$387.98
Radiation treatment, intermediate 6-10 MEV	333	1.4826	77408		$293.22	$387.98
Radiation treatment, intermediate 11-19 MEV	333	1.4826	77409		$293.22	$387.98
Radiation treatment, intermediate 20 MEV	333	2.2295	77411		$293.22	$387.98
Radiation treatment, complex 4 MEV	333	2.2295	77412		$372.71	$493.17
Radiation treatment, complex 6-10 MEV	333	2.2295	77413		$372.71	$493.17
Radiation treatment, complex 11-19 MEV	333	2.2295	77414		$372.71	$493.17
Radiation treatment, complex 20 MEV	333	2.2295	77416		$372.71	$493.17
IMRT, daily treatment	333	5.4731	77418		$2,541.21	$3,362.48
Special, treatment procedures	333	5.8839	77470		None available	
Intracav. application, simple	312	4.8569	77761		$203.84	$252.54
Intracav. application, intermediate	312	4.8569	77762		$301.37	$373.38
Intracav. application, complex	312	4.8569	77763		$331.94	$410.77
Interstitial radioelement application, simple	312	4.8569	77776		$214.91	$265.95
Interstitial radioelement application, intermediate	312	4.8569	77777		$438.90	$543.75
Interstitial radioelement application, complex	312	16.8462	77778		$481.99	$610.87
HDR brachy, simple 1-4 sources	333	12.8473	77781		$1,665.51	$2,064.03
HDR brachy, simple 5-8 sources	333	12.8473	77782		$1,648.35	$2,043.57
HDR brachy, complex 9-12 sources	333	12.8473	77783		$1,657.27	$2,052.92
HDR brachy, complex 12 sources	333	12.8473	77784		$1,706.23	$2,114.43
Linear accelerator, stereotactic radiosurgery, complete	333	63.3759	G0173		None available	

APC Description	Rev Code	Relative Weight	HCPCS CPT	Current Charge**	50th %ile	75th %ile
Linear accelerator-based stereotactic radiosurgery, first hour	333	20.3224	G0251		None available	
Robot linear accelerator radsurg complete, first hour	333	63.3759	G0339		None available	
Robot linear accelerator radsurg fractx 2-5 hours	333	43.0297	G0340		None available	
Surface application of radioelement	333	1.4826	77789		$40.25	$49.81
Therapeutic radiology port films	333	0.7093	77417		$88.61	$117.26
Treatment devices, simple	333	2.943	77332		$141.02	$186.67
Treatment devices, intermediate	333	2.943	77333		$197.09	$260.68
Treatment devices, complex	333	2.943	77334		$340.57	$450.55
Brachytx source, Gold 198	333	0.5991	C1716		None available	
Brachytx source, HDR Ir-192	333	2.3195	C1717		None available	
Brachytx source, Iodine 125	333	0.591	C1718		None available	
Brachytx source, Non-HDR Ir-192	333	0.3765	C1719		None available	
Brachytx source, Paladium 103	333	0.7942	C1720		None available	
Brachytx source, Yttrium-90	333	172.2337	C2616		None available	
Brachytx source solution, I-125, per mCi	333	N/A	C2632		None available	
Brachytx source, Cesium-131	333	1.4779	C2633		None available	
Brachytx source, HA I-125	333	0.5316	C2634		None available	
Brachytx source, HA P-103	333	0.8878	C2635		None available	
Brachytx linear source, P-103	333	0.6427	C2636		None available	
Brachytx, Ytterbium-169	333	_	C2637		None available	

* Unadjusted national numbers
** Technical charges only
*** Replaces 76370; 50% $375.80 75% $471.94

Chapter 2

Charge Capture

Tips

- Each patient's insurance coverage should be re-verified at the beginning of each year and every month thereafter…

- Pre-authorization generally requires a detailed treatment plan including ICD-9 codes and J-codes for drugs in treatment regimens.

Schedule and Register Patients

Your first contact with a patient is generally an appointment scheduled on the telephone. To expedite the scheduling process and assure getting the right information from this call, you should develop a form that has all the demographic and insurance information you will need to register the patient. This information should include the following:

Name
Address
Home telephone number
Date of birth
Social Security number
Employer
Work phone number
Insurance information: ID and group numbers

Verify Insurance Coverage

(See Insurance Verification Policy in Appendix I.)

A financial counselor should be responsible for completing the following sections of the insurance verification form prior to the patient's scheduled appointment for medical oncology. Each patient's insurance coverage should be re-verified at the beginning of each year and every month thereafter, or when the patient notifies the hospital that his or her insurance coverage has changed.

Patient name
Date of birth
Date patient called
Scheduled by
Date
Insurance name (Primary)
Guarantor
Relationship
Policy #
Group #
Insurance name (Secondary)
Guarantor
Relationship
Policy #
Group #

Once you have completed the insurance verification form with the sections just listed, contact the primary insurance company and verify coverage for the patient. Complete the following sections:

- Phone number—Phone number of the insurance company used to verify patient's insurance
- Contact person—Name of the person who provided the verification information
- Annual deductible
- Precertification requirement
- Referral requirement, if a referral is required
- Co-payment—Verify that the patient's insurance requires a co-payment, and verify if that co-payment is required for each daily treatment.

Once you have verified the primary insurance coverage, contact the secondary insurance company and repeat the process.

Under no circumstances should the patient be treated prior to verification of the primary and secondary insurance.

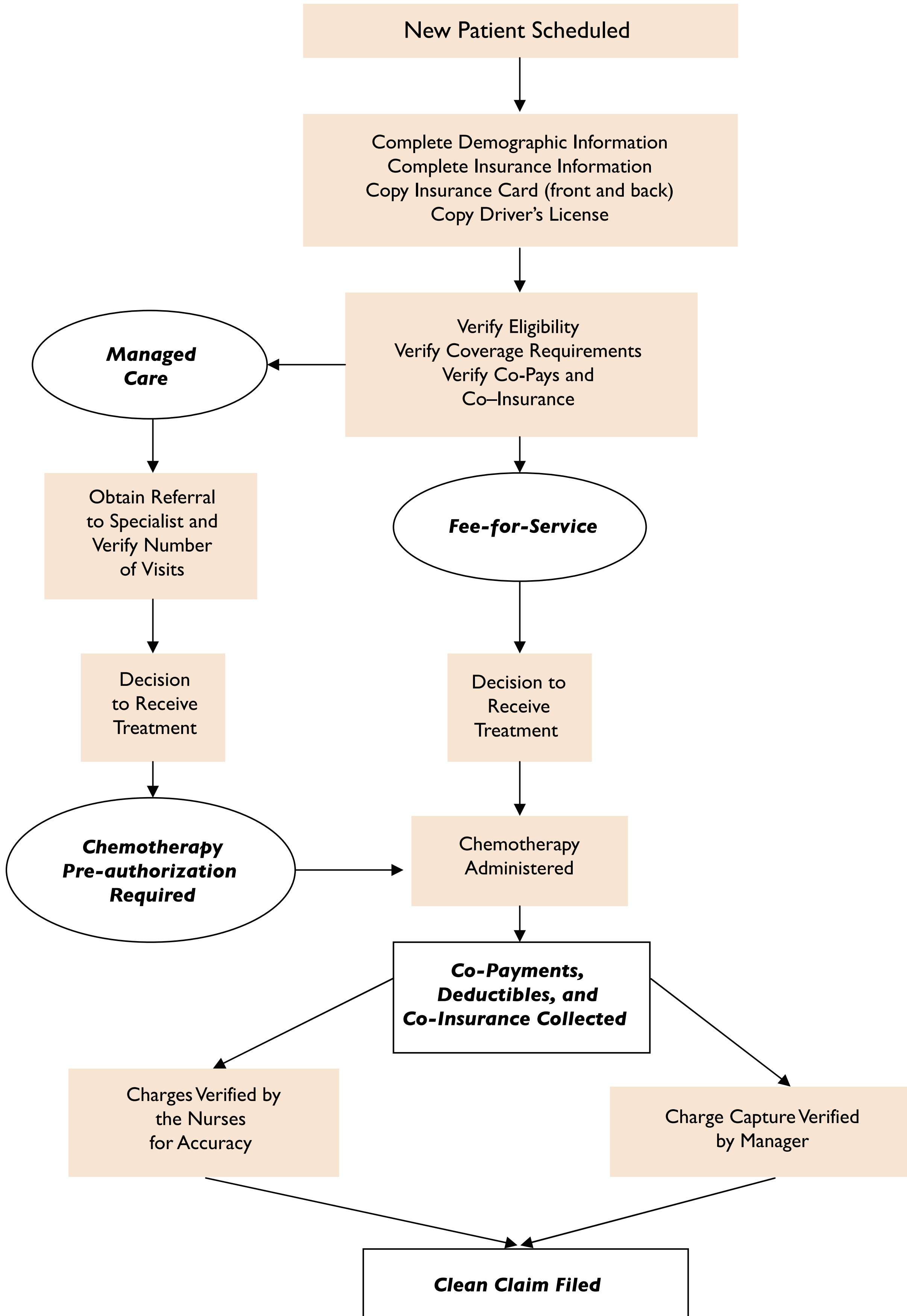
Pre-authorize Treatment

(See Treatment Pre-authorization Policy in Appendix I.)

Insurance carriers are increasing their requirements for pre-authorization, particularly for high-cost drugs, imaging, IMRT, and IGRT. Many have begun to outsource diagnostic imaging pre-authorization to companies specializing in assuring medical necessity. When a patient has made the decision to receive chemotherapy or radiation treatment, the hospital must verify any pre-authorization requirements with the patient's insurance company. Pre-authorization generally requires a detailed treatment plan including ICD-9 codes and J-codes for drugs in treatment regimens. This plan is then sent to a utilization department at the insurance company and approval is obtained or denied. Depending on the payer, you may be able to work collaboratively on a "fax" authorization process. For your major payers, this process works better for you and the payer. If approved, an authorization

continued on page 16

Figure 1: Charge Capture



Tips

- At the conclusion of the visit, all deductibles, co-payments, and co-insurance should be collected from the patient.
- Co-payments, co-insurance, and deductibles cannot be waived, and the patient should be made aware of his or her financial obligation prior to the visit.

number is used to indicate acceptance of the plan and duration. If treatment is denied, an appeal process can be used to attempt authorization. If the patient decides to initiate treatment prior to authorization from the insurance company, the patient should sign an advance beneficiary notice (ABN) indicating that he or she will be responsible for any charges incurred. If the patient is a Medicare patient, and an ABN is not signed, you cannot bill the patient if the service is denied for any reason.

The following steps should be taken when pre-authorizing treatment:

- Enter the ordering physician's name.
- Enter the hospital or group name as assigned by the insurance carrier.
- Enter the patient's insurance carrier name.
- Enter the insurance carrier fax number.
- Enter the patient's insurance ID.
- Enter the patient's name, date of birth and Social Security number.
- Enter narrative diagnosis and corresponding ICD-9 code.
- Indicate CPT codes for lab tests and enter how often they must be done per the physician order.
- Indicate HCPCS code, drug name, dose, route and frequency for all premeds.
- Complete and enter the HCPCS code, drug names, dosages, routes, and frequency for any and all medications ordered.
- Enter other information as indicated in the physician orders.
- Enter HCPCS codes for any and all discharge medications ordered.
- Enter the treatment start date.
- Have the ordering physician sign and date the request form.
- Give the form to the financial counselor to fax to the insurance carrier. Always keep a copy of the submission confirmation.

Allow 24 to 36 hours for a response from the insurance carrier. If you have not received a response within that time frame, follow-up must be done via phone or fax.

Once the authorization has been obtained, the financial counselor will notify the appropriate parties.

Many insurance carriers are making subtle changes in their plans, as are many employers in their self-insured plans. You must do everything possible to understand the details of patient coverage as identified in your patients' plans. Today even though pre-authorization is not required by many commercial plans, you may want to use it as a way to protect your patients and yourself. Some plans refuse to pay for any off-label drug use without two peer-review journal articles showing improved survival.

Collect Deductibles, Co-payments, and Co-insurance

At the conclusion of the visit, all deductibles, co-payments, and co-insurance should be collected from the patient. Co-payments, co-insurance, and deductibles cannot be waived, and the patient should be made aware of his or her financial obligation prior to the visit.

Use Encounter Forms

(See Encounter Forms in Appendix II.)

Encounter forms serve many purposes, and a well-developed encounter form can be invaluable to your program. The front of the form should include the following:

- Patient demographic information including insurance
- Date and scheduled appointment time
- Physician scheduled with patient
- Reason for visit and every diagnosis for which the patient is being treated
- CPT/charge codes for all the services provided
- Any other information needed to expedite the patient's visit.

The front of an encounter form is derived directly from the chargemaster. The back side of an encounter form should contain ICD-9 codes used most often in the practice. Making these easily accessible to the physician and nurse can make the process of coding a visit more efficient, exact, and specific.

The following steps should be followed when completing an encounter form:

- Print a Medical or Radiation Oncology

Encounter Form for each patient the evening prior to his or her scheduled visit or before the patient is seen.

- Enter all required demographic information, either through the computerized system or by hand.
- Place the completed encounter form on the outside top cover of the patient chart with a paper clip.
- The ICD-9-CM diagnosis information will be completed by the center physician or nursing staff. All procedures and drugs used during a patient's treatment should be marked on the encounter form as the service occurs.
- After the physician has completed the visit, he or she will return the patient chart with the completed encounter form to the reception area.

Assure Charge Capture Quality

The following procedures should be followed to assure charge capture (see Figure 1: Charge Capture, page 15):

- Batch all forms for the day and attach a Medical Oncology Daily Encounter Form Summary.
- Verify that the demographic data are complete for each patient and that each scheduled patient has an encounter form or cancellation/no show status, and sign the summary sheet.
- Return the batch to the Nurse Manager for review of the clinical services for accuracy and clinical logic. The Nurse Manager will review, correct as appropriate, and sign the summary sheet. He or she will return the batch to the receptionist.
- Enter charges as recorded for each patient within one day of service. Bill for each service you provide and for each service to which you are entitled because the figures on your cost report have the potential to affect your payment rates later on.

If the hospital staff provides physician support services, the hospital may bill for a visit service, whether or not the physician sees the patient. If a medical oncology patient is seen by the nurse, nutritionist, and social worker, the aggregate visit level should be billed. A patient seen by multiple physicians in multiple departments could have multiple billable visits on one day, but a patient seen by one physician can have only one billable visit on one day.

Each hospital must define and write its own standards for outpatient visit services. The emergency room is the only department allowed its own rule set. Escalating visit levels must correspond to greater use of hospital resources. Ordinarily, there are five visit levels. Oncology, however, has an additional level, used for interdisciplinary team visits if at least three staff members work with the patient and at least one is a physician. Critical care visits (99291) may be billed if a patient meets the definition of critically ill, as described in the American Medical Association coding manual. This code would most likely be used in the infusion area if a patient has a severe reaction to the drugs administered.

Anytime more than one visit (facility charge associated with visit service) is provided on the same day (visit to multiple clinics, or clinic and ER), the condition code G0 must be used on each claim other than the first claim. The logistics of applying condition code G0 are tricky at best. (Usually, the G0 code is entered by the billing department.)

In 2007 many medical and radiation oncology billing codes were deleted and replaced by new CPT codes. When choosing the correct billing code, CPT codes provide a much more detailed description of the services provided in the outpatient department. Use of the correct codes is critical and will require detailed education this year. Ensuring that all billable services from a clinical and clerical perspective are appropriately recorded and charged will provide CMS with a clear picture of the services actually being provided.

Use Modifiers Correctly

The use of modifiers for certain services and condition codes is critical if hospitals are to eliminate claim returns or denials. The largest impact on oncology comes from requirements for modifiers 25 and 59, and condition code G0. Modifier 25 must be used any time a visit facility fee is charged and a significant service is provided on the same day. For example, this modifier should be used every time an assessment visit and chemotherapy are provided on

Tips

- …physicians should add an ICD-9-CM code to every drug order. Doing so will help pharmacists verify coverage for that use and add the information to the patient's claim.
- Diagnosis codes must be updated at each visit as appropriate.

Tips

- Drugs approved by the Food and Drug Administration and prior to assignment of a Medicare billing code should be billed as C9399. This code is for both drugs and/ or biologicals. Payment rate is set at 95 percent of AWP (average wholesale price) or WAC (wholesale acquisition cost).

- …compare the transaction register to the Encounter Forms entered to verify that all charges have been entered appropriately prior to closing out the charge batch.

the same day, or radiation treatment and the weekly management visit are provided on the same day.

Modifiers are required for many radiation therapy and medical oncology procedures provided on the same day of service. A 59 modifier is attached to the code for the lesser service and indicates that the lesser service is separate and distinct and was not done as part of the greater procedure. A 25 modifier is attached to the visit service code any time a visit service is provided in addition to a major procedure such as chemotherapy or blood administration. If ancillary services (such as port films or injections) are provided with a major service, no modifier is needed. If two or more radiation treatments are provided with a distinct break in therapy sessions on the same day, use modifier 76 to indicate that the sessions are distinct treatments by the same physician. Remember to put each treatment on a separate line on the claim, and do not use units of more than one.

Verify and Update Diagnosis Codes

We recommend that physicians add an ICD-9-CM code to every drug order. Doing so will help pharmacists verify coverage for that use and add the information to the patient's claim.

Oncology infusion outpatients are likely to have a high volume of ICD-9-CM code additions and deletions. Medical records must be notified about any coding changes if the authority for making such changes on the bill rests with the Health Information Management Department (Medical Records).

Diagnosis codes must be updated at each visit as appropriate. Improper diagnosis codes or lack of specific diagnosis codes will create denials. Cancer center directors should immediately review the process for adding diagnosis codes to single entry and series accounts at their hospitals. Actively follow up to make sure your changes are incorporated into your hospital's system.

Educate and Keep Close Tabs on the Pharmacy

In the APC system, drugs must be billed in J-code units, which identify units of use. Some drugs have multiple J-codes. Usually only one J-code is paid. (Exceptions include filgrastim and reteplase, which have two payable codes.) All pharmaceutical doses should be rounded up to whole units. If the code is stated per 500 mg for example, but 1,100 mg were given, the correct number of units is 3. Never use decimal points. It is important to note that pharmacy systems are not billing systems. They were designed to track drug usage by patient and monitor inventory. Many pharmacy systems will require a multiplier to convert the dosage to billable J-code units. Make sure your claims represent what was actually given to the patient.

Your pharmacy system should add waste to patient dose for correct billing. Create a written policy that identifies any drugs that the pharmacy will waste once the vial is opened. Bill for all waste, as long as the patient received some of the drug. If the vial contains 100 mg and 80 mg were used and 20 mg wasted, 100 mg is billed. **No billed product should ever be used again on another patient.**

As of 2004, drugs approved by the Food and Drug Administration and prior to assignment of a Medicare billing code should be billed as C9399. This code is for both drugs and/or biologicals. Payment rate is set at 95 percent of AWP (average wholesale price) or WAC (wholesale acquisition cost). To be paid, all claims need to include the drug NDC number and exact milligrams of drugs used and associated waste.

Reconcile Charges

Once all charges have been entered for a particular day, the manager will print a transaction register from the charge data entry system. He or she should compare the transaction register to the encounter forms entered to verify that all charges have been entered appropriately prior to closing out the charge batch.

After data entry is complete, file the batched encounter forms, the summary sheet, and the transaction register in the central billing files for reference as needed.

Claims Production

Scrub Claims

After encounter forms have been reviewed for accuracy, they are posted to the patient's account. When all encounter forms for that day have been posted, a report is generated. This report indicates any claims that do not meet standard edits that are pre-programmed in the billing scrubber software. This function is called "scrubbing" the claims. The "scrubber" is created to use the same electronic edits as those used by Medicare. It is critical that scrubber software is updated quarterly and in coordination with Medicare rules. Otherwise, your system may reject claims that are valid and/or accept claims that are not.

Generate Error Reports

The report generated by scrubbing the claims is called an error or exception report. The report indicates any conflicting information it detects from the patient's posted charges. This report picks up small errors in specific fields of the claim form but should never be used to replace the personal auditing process completed prior to posting charges. The oncology department should review the error or exception reports every month in addition to the Billing Department review. Sometimes rule changes occur that oncology has been alerted to and which have not reached the scrubber program. This review allows you to create the most accurate claims and assures maximization of allowed services claims.

Print Claims

After a claim has been reviewed, a hard copy can be printed on a UB-92 or HCFA 1500 form. Generally speaking, hard copy claims are used when insurance companies require medical records to accompany the claim. Sending claims on paper is slower and requires a greater amount of time on the part of the insurance carriers to process the payment. Most software offers a faster and more efficient electronic claims processing function. Most payers can accept electronic claims submission.

Submit Claims

Once a claim has been scrubbed and errors on the batch report have been corrected, that claim is ready for submission to an insurance carrier. (See Figure 2, page 20.) ◆

Tip

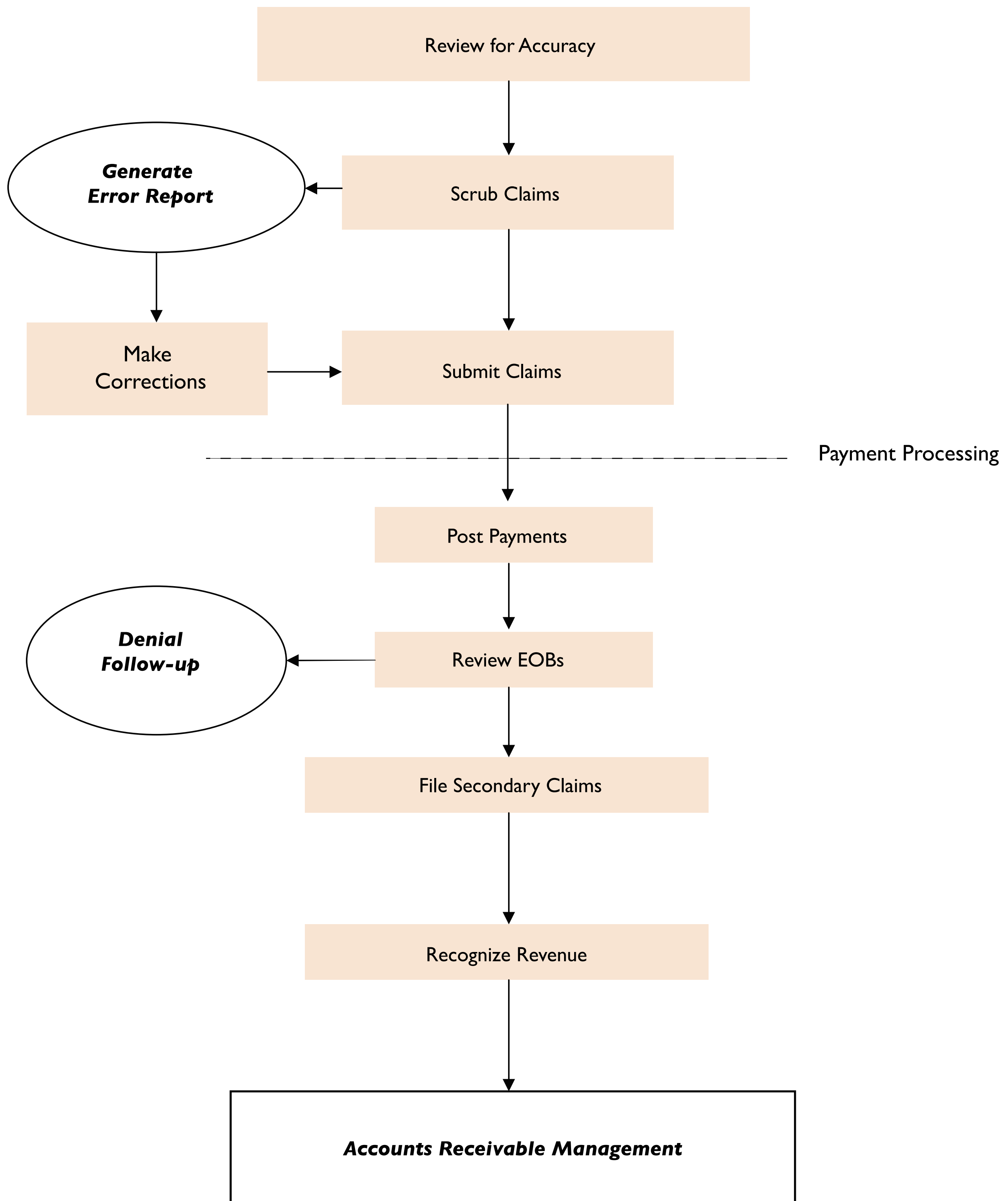
- Quality Indicators will most likely be mandatory to receive full HOPPS payment in 2008 and beyond.

Update Your Information Systems

Hospitals have greater incentive then ever to update their information systems not only for operations and automation of processes such as claims production and error report review but also to provide e-solutions for critical areas such as clinical documentation, prescription generation, and decision support. Today, physicians are selecting hospitals that offer the convenience of technology that allows them real-time access to patient data and enables documentation of care and communication connection between the hospital, their offices, and off-site practices. The Social Security Act (SSA) Section 1877(b)(4) Rule 411.375(w), August 8, 2006, created an exception to the physician self-referral ("Stark") prohibition. This rule creates a separate regulatory exception for certain arrangements involving the provision of non-monetary remuneration in the form of electronic health records software or information technology (IT) and training services necessary and used predominately to create, maintain transmit, or receive electronic health records. The Health Information Technology Promotion Act of 2006 establishes "safe harbors" that permit hospitals, medical groups, Medicare Advantage plans, and prescription drug plans to donate health information technology to physicians. This is a significant step in enabling providers to implement streamlined documentation through the use of e–technology, thus improving hospitals' documentation and ultimately reimbursement.

Visit *http://www.cms.hhs.gov/PhysicianSelfReferral/Downloads/CMS-1303-F.pdf*
Federal Register, *August 8, 2006, for greater detail regarding the SSA Rule.*

Figure 2: Claims Production and Payment Processing



Payment Processing

Ensure Communication and Coordination among Departments

The Patient Accounts department will require help to handle the oncology returns/denials, since its staff is not trained to answer improper diagnosis or medical necessity questions. Meet with the supervisor and arrange a schedule (daily or perhaps weekly, depending on the size of your program) to pick up all cancer-related returned/denied bills. Spend some time with the supervisor to learn how to read the reasons for return/denial so you can review them easily and correct them quickly. For example, note corrected service dates or check for mismatches between ICD-9-CM diagnosis codes and drug codes. Work with the departments that made the errors, so they are clear about your corrections. If the bill requires appeal, you may need to involve your medical director, especially if the issue is medical necessity.

It's worth repeating that in every successful hospital outpatient program, each service department will be responsible for working with Patient Accounts, Information Services, Medical Records, and Managed Care. *Every* support department will be accountable for working with the service departments.

Post Payments

Payments are received from insurance carriers in the form of "bulk" checks. The bulk remittance, Explanation of Benefits (EOB), does not detail each patient's charges or the allowed amounts by the carrier. Presently, most fiscal intermediaries do not have the ability to provide line item reimbursement. CMS is working toward that solution.

This bulk system adds to the complexity of accurately applying payments to actual services. Work with Patient Accounts to develop an internal system. After the payment is posted and reviewed, the amount remaining on the claim should be zero for the patient's responsibility unless there is a balance owed by the secondary insurance or the patient.

Review EOBs at Posting

Paid claims need to be reviewed by payer group to make sure that the insurance carrier has paid each covered line item on the claim and at the contracted rate. Reviews show that hospitals are underpaid on average by 3 to 5 percent of contract allowance.

Be Proactive with Suspended or Denied Claims

Medical records that are required to process a claim should be obtained and returned to the insurance carrier as soon as possible so the claim can be paid. If a carrier has known problems processing specific claims, immediately send the claim with the supporting documentation on paper as you file the electronic claim. Be proactive with your insurers to assure proper and prompt payment. Nearly 75 percent of all claims suspended or denied are ultimately paid when pursued.

Review Denied Claims and Follow Up

Department managers must take a strong role in collection and assist patient accounts with resubmission of any returned claims. Ask for and review your denials daily. Attach the documentation and appeal paperwork and give them back to the proper location for appeal in a timely manner.

Staff in the Patient Accounts department should be just as concerned with making sure that every charge gets collected as they are with correct billing and days in accounts receivable.

All denied claims should be reviewed for:

- Correct and appropriate coding and posting.
- Track rejections by CPT code and payer to determine if your coding needs review or the carrier has denied the claim in error.
- Additional medical records requested by the carrier.
- Verification that a service is actually non-covered.

All actions taken to expedite payment of denied claims should be documented in the patient's chart under a section designated for financial

Tips

- Paid claims need to be reviewed by payer group.
- Track rejections by CPT code and pages to determine if your coding needs review or the carrier has denied the claim in error.
- You may have increased denials for new drugs and technology services. Consider challenging unusual denials such as non-payment for any off-label drug use that appears without notice, if pre-authorization was not required.

Tips

- Accurately complete insurance forms on new identification numbers or re-file claims to those insurers that have not paid in 30 to 45 days.

- . . . a well-developed process for charge preparation, capture, production, and payment processing can mean the difference between success and failure.

information. (See Insurance Denial and Follow-Up Policy in Appendix I.)

File Secondary Claims

Secondary claims can be submitted to the secondary carrier at this point. Medigap now provides electronic processing for Medicare Medigap policies. Other claims will have to be filed on hard copy claim forms. A copy of the primary carrier's Explanation of Benefits should accompany the secondary claim.

Recognize Department Revenue

Revenue and expense recognition is a function of the Accounting department. Many small businesses use the cash accounting method, which recognizes expenses when paid and revenue when received. Larger businesses and hospitals use the accrual method of accounting, which recognizes expenses when they occur and revenue when the service is provided.

Regardless of which accounting method is used, all business depends on cash flow if it plans on continuing. In today's sophisticated market, a well-developed process for charge preparation, capture, production, and payment processing can mean the difference between success and failure.

Again, your charges must represent the cost of providing the services, and all billable services must be billed. It is imperative that you keep abreast of all Medicare, Medicaid, and third-party payer requirements, and understand how and what is paid for each procedure.

You may encounter resistance from senior management regarding your department's specific needs. It is possible that the organization's financial goals are not aligned directly with your department, so document all discussions with senior management. When it comes time to discuss your budget, you can remind management of your previous requests.

Have Accounts Receivable Follow Up

Patients who have not paid should be grouped into the following categories:

- Those who pay bills in full or pay on a planned monthly schedule, as soon as they are rendered.
- Those who routinely, regardless of the nature of the bill, refuse to make payments until they are pressured over and over again. This category also includes individuals who feel that physician's bills are too high; that it is the physician's responsibility to provide care regardless of payment; or that credit card and other high-interest loans should be paid first. Finally, this category includes individuals who perceive, either from previous patients, their referring physicians, the hospital referral service, or the community that the office's collection process is administered or enforced in a weak manner or is not a priority.
- Those who need care and are absolutely financially stressed. These are the true hardship cases, requiring human and professional compassion and deserving of write-offs on balances or total bills.

Once patients have been categorized, staff members in Patient Accounts need to complete two basic tasks for all three categories:

- Re-verify the insurance company or carrier's name, address, and patient's identification number for *all* coverage. (Many patients only provide information on their primary insurance coverage and neglect to submit information on secondary benefits purchased independently or provided through their spouse's employment.)
- Accurately complete insurance forms on new identification numbers or re-file claims to those insurers that have not paid in 30 to 45 days. This document should also include either written or verbal follow-up with the insurance representative. For non-participating providers, the hospital, in addition to completing the initial insurance form required by law, needs to provide the patient with an accurate and detailed itemized statement along with the correct CPT and ICD-9-CM codes *and* description.

Once these activities are completed, the hospital must pursue the patients identified as financially stressed. Have the receptionist, nurse, and/or financial counselor develop a closer relationship with the patient to obtain a true assessment of the patient's financial situation. ◆

Medical Oncology 2007

Chapter 5

The year 2007 brings significant changes in infusion services. Medicare continues the policy of reimbursing drugs, biologicals, and radiopharmaceuticals at average sales price (ASP) plus 6 percent with some continued exceptions. Clinic visit services will continue for another year using physician visit (E&M) CPT codes.

Reimbursement Outlook

Quality indicators for future outpatient reimbursement are being developed by CMS during 2007 for implementation next year and beyond. It will be essential to understand and implement changes to capture critical data. Additionally, it will be important to educate your staff in 2007 regarding all of the rule changes in order to capture full payment in the future.

Infusion Services

The following sections provide information on the 2007 changes for infusion administration codes and payments, a review of clinic visits, and updated billing guidelines for blood and blood products.

Administration Codes

In response to comments from payers regarding the burden of tracking two different sets of codes, C-codes will *not* be used for administration. CMS will adopt the additional 13 of the 33 codes for administration and will be keeping the temporary code C8957, *Intravenous infusion for therapy/diagnosis; initiation of prolonged infusion (more than 8 hours), requiring the use of portable or implantable pump,* until a permanent code is assigned. Table 1 (see page 24) provides a list of the current administration codes and payments.

Some additional notes provides by CMS in response to comments include:

- You can bill only one IV push code per drug, which means if you push the same drug twice during the treatment regimen you can only bill one IV push code.
- You can bill only one initial hour of infusion. An example is noted in the Final Rule in which a commenter proposed to bill separately and receive payment for the first hour of therapeutic infusion and hydration infusion when provided in the same encounter. CMS responded that this would not be consistent with CPT coding principles.

Concurrent codes will not be reimbursed in 2007. CMS will need claims data for future claims and indicates that reimbursement is already packaged into 2007 payments.

Clinic Visits

CMS has decided not to implement the proposed G codes for clinic visits. Hospital outpatient centers will continue to bill using CPT codes. CMS will await development of a national set of facility-specific codes and guidelines. Several different models have been reviewed including those based on staffing interventions, staff time spent with the patient, resource intensity point scoring, and severity acuity point scoring related to patient complexity. CMS concluded that the models reviewed were too complex, or provided significant potential for up-coding.

In September 2004, CMS contracted a retrospective study using clinic and emergency guidelines established by the American Hospital Association (AHA) and the American Health Information and Management Association (AHIMA). The study was originally scheduled to review 12,500 visits and was aborted after 750 audits. The contractor identified a number of elements in the guidelines that were difficult for coders to interpret, were poorly defined, nonspecific, or were regularly unavailable in the medical records.

CMS advises that each hospital's internal guidelines follow the intent of the CPT code descriptors. Your hospital-wide clinic visit guidelines should be designed to reasonably relate the intensity of hospital resource utilization to the different levels of effort represented by the codes.

Blood and Blood Products

According to the American Red Cross, the Medicare 2004 claims from 80 percent of hospitals that submitted blood and/or blood processing represented less than 20 percent of the total units of blood estimated to be transfused in the

Table 1. Infusion Administration Codes and Payments

Old HOPP	2006 HOPP	2007 HOPP	Description	2006 Payment	2007 Payment
90780		90760	Intravenous infusion, hydration; initial, up to 1 hour	120.77	111.20
90781		90761	(Add-on code) each additional hour	0.00	24.25
90780	C8950	90765	Intravenous infusion, for therapy, prophylaxis, or diagnosis, (specify substance or drug); initial, up to 1 hour	120.77	111.20
90781	C8951	90766	(Add-on code) each additional hour	0.00	24.25
90781		90767	(Add-on code) additional sequential infusion, up to 1 hour	0.00	24.25
		90768	(Add-on code) concurrent infusion	N/A	0.00
90782	90772	90772	Therapeutic, prophylactic or diagnostic injection (specify substance or drug); subcutaneous or intramuscular	23.31	24.25
	90773	90773	Therapeutic, prophylactic or diagnostic injection (specify substance or drug); intra-arterial	47.82	48.82
90784	C8952	90774	Therapeutic, prophylactic or diagnostic injection (specify substance or drug); IV push	47.82	48.82
		90775	(Add-on code) Therapeutic, prophylactic, or diagnostic injection (specify substance or drug)	N/A	48.82
	90779	90779	Unlisted therapeutic, prophylactic or diagnostic intravenous or intra-arterial injection or infusion	8.14	11.12
96400	96401	96401	Chemotherapy anti-neoplastic, subcutaneous or intramuscular	68.37	48.82
	96402	96402	Chemotherapy hormonal anti-neoplastic subcutaneous or intramuscular	68.37	48.82
	96405	96405	Chemotherapy administration; intralesional, up to and including 7 lesions	68.37	48.82
	96406	96406	Chemotherapy administration; intralesional, more than 7 lesions	68.37	48.82
96408	C8953	96409	Chemotherapy administration; intravenous push technique, single or initial substance/drug	68.37	97.41
96408		96411	(Add-on code) chemo IV push, additional drug	67.65	97.41
96410	C8954	96413	Chemotherapy administration, intravenous infusion technique; up to 1 hour, single or initial substance/drug	189.04	152.75
96412	C8955	96415	(Add-on code) chemo infusion, each additional hour	0.00	48.82
	96416	96416	Chemotherapy administration, intravenous infusion technique; initiation of prolonged chemotherapy infusion (more than 8 hours), requiring use of a portable or implantable pump	189.04	152.75
96412		96417	(Add-on code) chemo infusion, each additional sequential infusion, (different substance/drug)	N/A	48.82
	96420	96420	Chemotherapy administration, intra-arterial; push technique	68.37	97.41
	96422	96422	Chemotherapy administration, intra-arterial; infusion technique, up to 1 hour	189.04	152.75
	96423	96423	(Add-on code) chemotherapy administration, intra-arterial; infusion technique, each additional hour (List separately in addition to code for primary procedure)	0.00	48.82
	96425	96425	Chemotherapy administration, intra-arterial; infusion technique, initiation of prolonged infusion (more than 8 hours), requiring the use of a portable or implantable pump	189.04	152.75
	96440	96440	Chemotherapy administration into pleural cavity, requiring and including thoracentesis	68.37	152.75
	96445	96445	Chemotherapy administration into peritoneal cavity, requiring and including peritoneocentesis	68.37	152.75
	96450	96450	Chemotherapy administration, into CNS (e.g., intrathecal), requiring and including spinal puncture	105.28	152.75
96530	96521	96521	Refilling and maintenance of portable pump	113.20	111.20
	96522	96522	Refilling and maintenance of implantable pump or reservoir for drug delivery, systemic (e.g., intravenous, intra-arterial)	113.20	111.20
	96523	96523	Irrigation of implanted venous access device for drug delivery systems	0.00	31.36
	96542	96542	Chemotherapy injection, subarachnoid or intraventricular via subcutaneous reservoir, single or multiple agents	68.37	48.82
	96549	96549	Unlisted chemotherapy procedure	68.37	11.12
	C8957	C8957	Prolonged IV infusion, regular pump	120.77	152.75

Table 2. 2007 Payment Median Costs for Blood and Blood Products*

*Higher of CY 2007 Simulated Median Unit Cost or 75 Percent of CY 2006 Adjusted Simulated Median Unit Cost (Payment at 75 percent of CY 2006 Median)

HCPCS	APC	Description	2007 Units	2007 Unadjusted Simulated Median Unit Cost	2007 Payment Median*	2006 Unadjusted Simulated Median Unit Cost	2006 Adjusted Simulated CCR Median Unit Cost	% Change 2006-2007 Adjusted Simulated CCR Median Unit Cost
P9010	0950	Whole blood for transfusion	2,575	$131.21	$131.21	$117.91	$117.91	11.28%
P9011	0967	Blood split unit	190	$136.42	$136.42	$82.50	$82.50	65.36%
P9012	0952	Cryoprecipitate each unit	5,136	$48.31	$48.31	$40.33	$47.10	2.57%
P9016	0954	RBC leukoreduced	618,531	$174.71	$174.71	$163.16	$163.16	7.08%
P9017	9508	Plasma 1 donor froz w/in 8 hr	46,863	$69.80	$69.80	$70.40	$70.40	-0.85%
P9019	0957	Platelets, each unit	28,399	$58.61	$58.61	$51.50	$51.50	13.81%
P9020	0958	Platelet rich plasma unit	711	$153.79	$208.07*	$277.42	$277.42	-44.56%
P9021	0959	Red blood cells unit	161,250	$128.78	$128.78	$121.48	$121.48	6.01%
P9022	0960	Washed red blood cells unit	2,795	$209.79	$209.79	$172.40	$189.22	10.87%
P9023	0949	Frozen plasma, pooled, sd	433	$56.81	$57.11*	$60.38	$76.15	-25.40%
P9031	1013	Platelets, leukoreduced	21,507	$94.53	$94.53	$98.30	$98.30	3.84%
P9032	9500	Platelets, irrad	5,989	$128.81	$128.81	$73.46	$86.55	48.83%
P9033	0968	Platelets, leukoreduced, irrad	5,386	$124.60	$124.60	$102.18	$150.58	-17.25%
P9034	9507	Platelets, pheresis	10,689	$450.29	$450.29	$434.01	$434.01	3.75%
P9035	9501	Platelet pheresis, leukoreduced	46,661	$485.89	$485.89	$493.12	$493.12	-1.47%
P9036	9502	Platelet pheresis, irrad	1,620	$416.08	$416.08	$317.43	$325.87	27.68%
P9037	1019	Platelet pheresis, leukoreduced, irrad	20,231	$613.80	$613.80	$581.01	$581.01	5.64%
P9038	9505	RBC irrad	4,984	$195.85	$195.85	$147.47	$147.47	32.18%
P9039	9504	RBC deglycerolized	916	$356.22	$356.22	$343.44	$343.44	3.72%
P9040	0969	RBC leukoreduced, irrad	66,390	$216.29	$216.29	$218.04	$218.04	-0.80%
P9043	0956	Plasma protein fract,5%,50ml	442	$25.04	$50.96*	$67.94	$67.94	-63.14%
P9044	1009	Cryoprecipitate–reduced plasma	70,035	$81.91	$81.91	$74.52	$74.52	9.92%
P9048	0966	Plasmaprotein fract,5%,250ml	403	$138.85	$236.78*	$127.36	$315.70	-56.02%
P9050	9506	Granulocytes, pheresis unit	495	$260.17	$745.98*	$245.14	$994.64	-73.84%
P9051	1010	Blood, l/r, cmv-neg	3,913	$134.83	$155.79*	$207.72	$207.72	-35.09%
P9052	1011	Platelets, hla-m, l/r, unit	2,025	$667.70	$667.70	$609.48	$609.48	9.55%
P9053	1020	Platelets, pher, l/r cmv-neg, irrad	1,049	$701.26	$701.26	$654.13	$654.13	7.20%
P9054	1016	Blood, l/r, froz/degly/wash	586	$209.82	$209.82	$89.73	$261.93	-19.89%
P9055	1017	Plat, aph/pher, l/r, cmv-neg	598	$387.90	$394.50*	$526.00	$526.00	-26.25%
P9056	1018	Blood, l/r, irrad	4,037	$143.44	$143.44	$162.42	$178.37	-19.58%
P9057	1021	RBC, froz/deg/wsh, l/r, irrad	84	$493.32	$493.32	$345.53	$345.53	42.77%
P9058	1022	RBC, l/r, cmv-neg, irrad	2,301	$260.65	$260.65	$256.76	$266.89	-2.34%
P9059	0955	Plasma, froz between 8-24 hours	3,479	$76.32	$76.27	$74.70	$74.70	2.17%
P9060	9503	Froz plasma donor retested	320	$74.06	$74.06	$94.72	$94.72	-21.81%

United States. Given that Medicare is a significant payer for blood-related care, the information suggests that hospitals are not billing for services and or products provided.

On March 4, 2005 CMS issued, Transmittal 496, Billing for Blood and Blood Products under OPPS. The transmittal provided billing guidelines for hospital outpatient departments. It can be found at *http://cms.hhs.gov/transmittals/downloads/R496CP.PDF*.

In CY 2007 CMS will continue to use hospitals' blood-specific cost-to-charge ratio. CMS used claims data from CY 2005, which it believes represents a better sampling since the release of Transmittal 496. Table 2 provides the methodology and payment set by CMS for CY 2007. Seven of the 34 blood products listed have payment adjustments from 2006 as a result of the adjustments to the simulated median costs.

Medicare reimbursements are based on hospital charges for blood and blood related services, so it is important that hospitals capture and account all charges when reporting blood services. Table 3 provides a list of billing guidelines for blood related products and services covered by payers from the American Red

Table 3. Blood and Blood Products Billing Guidelines

Product or Service	OPPS Billing Guidelines
Blood or blood component	■ Bill for blood processing under revenue code 0390 (blood processing cost) and include HCPCS code, product specific P code.
Transfusion procedure	■ Bill under revenue code 0391 (transfusion procedure) and include appropriate CPT code that accurately describes the procedure performed. ■ CMS allows the transfusion procedure to be billed once per day.
Blood typing, cross-matching, and other laboratory services	■ Bill under revenue code series 030X (Laboratory) or 031X (Laboratory, Pathological) and include the specific CPT codes for blood typing, cross-matching, and other laboratory services related to the patient who receives the blood.

Cross' *Comprehensive Guide to Billing and Reimbursement for Blood, Blood Products and Related Services.*

Be sure to include:
- Processing fees for all blood units—whether allogeneic (homologous), autologous, or donor-directed—incurred by the blood supplier that are passed along to the hospital
- Costs incurred by the hospital to process and administer the blood after it has been procured, including handling, storage, delivery, and inventory management costs.

The American Red Cross' *Comprehensive Guide to Billing and Reimbursement for Blood, Blood Products and Related Services* is an excellent reference guide that provides a more comprehensive overview of CMS transmittal 496 and can be found at *http://www.redcross.org/services/biomed/profess/BillingGuide07Update.pdf.*

Drugs, Biologicals, and Radiopharmaceuticals

Understanding Average Sales Price (ASP)

In 2007, Medicare continues with the payment methodology initiated during 2006: ASP +6 percent. There were major concerns that CMS would alter the methodology used for hospitals, and this may still be an option in the future. The methodology is the response to the Medicare Modernization Act's (MMA) requirement that payment for drugs be *equal to* the average acquisition cost for the drug during that year, including adjustment for overhead costs. The CMS statistics must take into account the GAO study of hospital acquisition costs in CY 2004 and 2005. If data are not available, for example for a particular drug, then CMS must create payment rates equal to those rates established for physician payment.

CMS paid ASP+6 percent in 2006 and developed that payment rate as fair and reasonable by evaluating three data sources. These data included the following sources:
- GAO reported average purchase price for 55 drugs
- ASP data collected from drug manufacturers and reported to CMS for the physician drug payment
- Mean costs derived from hospital claims data for CY 2004.

CMS noted that findings of the MedPAC survey of hospital charging practices indicated that hospitals set charges for drugs, biologicals, and radiopharmaceuticals high enough to reflect their pharmacy handling costs as well as their acquisition costs.

CMS is required to evaluate whether in 2007 (and subsequent years) the payment rate for drugs and biologicals meets the average acquisition cost for *that* year and makes payment decisions accordingly. CMS must take into account adjustments for overhead costs and the GAO survey from CY 2004 and CY 2005. Additionally, Congress authorized CMS to adjust APC weights for drugs by taking into account the MedPAC report relating to overhead, such as pharmacy services and handling costs.

During 2006, CMS began evaluating ASP payment in the physician office as paid through the first quarter of 2006 and hospital claims data for 2005. After developing an equivalent average ASP payment rate under both methodologies and comparing the two, CMS created a proposed payment rate of ASP+5 percent. CMS believes that this payment covered average acquisition costs and pharmacy handling. CMS received many negative comments and in its final rule made the decision to utilize the ASP+6 percent payment rate for 2007.

CMS believes that the data from claims showed a payment rate of ASP+4 percent would have met the requirements of the MMA. CMS will continue its work to create fair and reasonable payment to hospitals based on their average acquisition cost. It is imperative for all hospital

oncology programs to work closely with their pharmacy director on price setting to adequately represent cost. As discussed for radiation services, claims data and cost reports data do not support increased payments and have impacted payment rates for these services.

Transitional Pass-through Payments for Additional Costs of Drugs and Biologicals

The MMA specifies that the duration of transitional pass-through payments for drugs and biologicals must be no less than 2 years and no longer than 3 years. Drugs and biologicals with a pass-through status in CY 2007 that are listed under the Part B drug CAP program will be reimbursed at the rate established by the Part B drug CAP program. All other drugs and biologicals will be paid at the current ASP+6 percent reimbursement rate.

Currently there are no radiopharmaceuticals that would have pass-through status in CY 2007. In the event that a new radiopharmaceutical agent receives pass-through status, reimbursement would be based on wholesale acquisition cost (WAC) since ASP data for radiopharmaceuticals are not available. If WAC is not available the payment would be calculated at 95 percent of average wholesale price (AWP) in keeping with the same process used for new drugs, biologicals, and radiopharmaceuticals. Tables 4, 5, and 6 provide a summary of the significant drugs and biologicals with expired pass-through status as well as those that qualify in 2007 for pass-through status.

Intravenous Immunoglobulin (IVIG)

Outpatient departments will continue to code G0332 *Pre-administration related services for intravenous infusion immunoglobulin, per infusion encounter,* for a payment rate of $75 to cover the extra cost of obtaining and mixing of IVIG. CMS will continue to collect data and will be awaiting results of two studies underway that will provide more information on IVIG supply, demand, and pricing. The Department of Health and Human Services (HHS) Assistant Secretary for Planning and Evaluation has commissioned a study to better understand the market for IVIG and evaluate the demand, supply, and access to IVIG. The HHS Office of Inspector General is also conducting a study on availability and pricing of IVIG.

Table 4. Oncology-related Drugs and Biologicals Whose Pass-through Status Expired in 2006

HCPCS	APC	Description
J0128	9216	Abarelix injection
J2783	0738	Rasburicase
J9035	9214	Bevacizumab injection
J9055	9215	Cetuximab injection
J9305	9213	Pemetrexed injection

Table 5. 2007 Oncology-related Drugs and Biologicals with Pass-through Status

HCPCS	APC	Description
J0894	9231	Decitabine injection
J2248	9227	Micafungin sodium injection
J8501	0868	Aprepitant oral
J9027	1710	Clofarabine injection
J9264	1712	Paclitaxel protein bound

Table 6. 2007 Oncology-related Drugs and Biologicals without OPPS Claims Data and without Pass-through Status

HCPCS	APC	Description
C9235	9235	Panitumumab injection
J8650	0808	Nabilone oral
J9261	0825	Nelarabine injection

Table 7. 2007 Exempt Anti-Emetics

HCPCS	Description
J1260	Dolasetron mesylate
J1626	Granisetron HCl injection
J2405	Ondansetron HCl injection
J2469	Palonosetron HCl
Q0166	Granisetron HCl, 1 mg oral
Q0179	Ondansetron HCl, 8 mg oral
Q0180	Dolasetron mesylate oral

Reduction in Threshold for Separate APCs for Drugs

Packaged Drug Costs

Drugs, biological, and radiopharmaceuticals having a per day cost less than $55 based on the updated ASPs and hospital claims data used for the CY 2007 final rule will remain packaged in CY 2007.

Anti-Emetics

CMS values the benefits provided by 5HT3 anti-emetics for chemotherapy patients during treatment. Medicare will continue to provide payment for the anti-emetics listed in Table 7 and considers them exempt from the $55 packaged drug cost. ◆

Chapter 6

Radiation Oncology and Oncology Imaging 2007

In 2007 radiation oncology reimbursement rates have stabilized. Medicare has effectively consolidated complex services into fewer procedures. For example, brachytherapy and stereotactic radiosurgery reimbursement have both moved towards bundling of complex services, while intensity modulated radiation therapy (IMRT) did not experience any coding or reimbursement changes in 2007.

Reimbursement Outlook

Although stabilization in payment rates is good in terms of assisting providers by packaging services that once required intricate billing and coding, it forecasts a potential future similar to what is already occurring in the commercial payer arena. That is, while Medicare simplifies the complexity of radiation oncology coding and reimbursement by limiting the number of codes and bundling groups of services into one chargeable code, it also minimizes the incentive for providers to expand the complexity of the technology because of the lack of payment differential for innovation in treatment.

It is important to continue monitoring the changes occurring in the private sector. It appears that cancer centers are facing greater scrutiny regarding the use of new technology as they experience greater limits in reimbursement. For example, Aetna is evaluating the use and costs associated with intensity-modulated radiation therapy (IMRT) in the treatment of breast cancer. National trends are leaning towards restricting choice and/or limiting the procedures that can be used.

The following sections provide a summary of the changes providers and hospitals are experiencing in 2007 in radiation oncology, particularly brachytherapy and radiosurgery services and appropriate coding and billing for services rendered. Coding and billing for IMRT have not changed in 2007. Conformal radiation therapy documentation, coding, and billing are provided as a review to assist staff in accurately documenting services and obtaining appropriate payment.

Brachytherapy

To determine 2007 payment rates for brachytherapy, CMS used CY 2005 claims data for brachytherapy sources and determined the median cost for the services. Table 1 provides the list of all separately payable brachytherapy sources for CY 2007 noted in the Final Rule. Note C-code C2632, *Brachytherapy solution, iodine 125, per millicurie* has been replaced with new code A9527, *Iodine I-125, sodium iodide solution, therapeutic, per millicurie*. The reporting of the assigned HCPCS code is required by hospitals in order to receive payment for the brachytherapy source. Device edits are not needed to ensure appropriate payment for brachytherapy procedures.

After the Final Rule was published in November 2006, CMS released Transmittal 1139, which stated that effective January 1, 2007, CMS would pay for specified brachytherapy sources separately, pursuant to the MMA, and at hospitals' charges adjusted to their cost pursuant to the Tax Relief and Health Care Act of 2006. This extends the charges adjusted to cost payment for brachytherapy sources until January 1, 2008. Therefore, the prospective payment rates in the Final Rule will not be used for payment in 2007.

Breast Brachytherapy

CMS agreed with commenters in 2007 and determined that CPT codes 19296 and 19297 accurately reflect the cost of the procedure, as well as their clinical features. CMS has assigned these codes to clinical APC 0648 re-titled *Level IV Breast Procedures* with a final median cost of $3,130.45. CMS emphasized that institutions need to ensure that future claims include charges for the necessary devices to assist in future rate setting. A procedure-to-device edit has been implemented for both of these breast brachytherapy procedures. Table 2 provides a summary of 2007 CPT and payment rates for codes 19296 and 19297.

There is concern from providers that APC 0648 has been assigned as a *Status Indicator T*. This means that if an additional service with Status Indicator T is reported together with APC 0648, then the lower of the services is paid at 50 percent. CMS believes that this reduction is appropriate and will help gain efficiencies when both the partial mastectomy and placement of brachytherapy catheter procedures are

Table 1. 2007 Separately Payable Brachytherapy Sources

HCPCS	Description	APC	2005 Median Cost
C1716	Brachytherapy source, Gold 198, per source	1716	$36.61
C1717	Brachytherapy source, High Dose Rate Iridium 192, per source	1717	$141.75
C1718	Brachytherapy source, Iodine 125, per source	1718	$36.12
C1719	Brachytherapy source, Non-High Dose Rate Iridium 192, per source	1719	$23.01
C1720	Brachytherapy source, Palladium 103, per source	1720	$48.53
C2616	Brachytherapy source, Yttrium-90, per source	2616	$10,525.13
A9527 (C2632 deleted)	Iodine I-125, sodium iodide solution, therapeutic, per millicurie	2632	$20.30
C2633	Brachytherapy source, Cesium-131, per source	2633	$90.31
C2634	Brachytherapy source, High Activity, Iodine-125, greater than 1.01 mCi (NIST), per source	2634	$32.49
C2635	Brachytherapy source, High Activity, Palladium-103, greater than 2.2 mCi (NIST), per source	2635	$54.25
C2636	Brachytherapy linear source, Palladium-103, per 1 mm	2636	$39.28

Table 2. 2007 Breast Radiotherapy Descriptions and Payments

CPT/HCPCS	Description	APC	2007 Payment
19296	Placement of radiotherapy afterload balloon catheter into the breast for interstitial radioelement applications following partial mastectomy; includes imaging guidance; on date separate from partial mastectomy	0648	$3,148.82
19297	Placement of radiotherapy afterloading balloon catheter into the breast for interstitial radioelement application following partial mastectomy; includes imaging guidance; concurrent with partial mastectomy (list separately in addition to code for primary procedure)	0648	$3,148.82

performed in the same operative procedure.

CPT Code 19160, *Mastectomy, partial* and code 19162, *Mastectomy, partial with axillary lymphadenectomy* are assigned to APC 0693 with CY 2007 final median cost of $2,260.98. This procedure should be reported when performed concurrently with placement of a brachytherapy balloon catheter in code 19297.

Stereotactic Radiosurgery

Stereotactic radiosurgery (SRS) has been coded under *New Technology* for three full years. At this time CMS believes that there are adequate data and, therefore, has moved SRS services into a *Clinical* APC. Table 3 (page 32) provides a summary of each code including 2006 median payment rates and the national payment rates for 2007.

Intensity Modulated Radiation Therapy

Although coding and billing for intensity modulated radiation therapy (IMRT) have not changed in 2007, IMRT coding and billing are complex and often pose challenges to hospital staff. A review of conformal radiation therapy documentation, coding, and billing are provided below.

Hospital Coding and Billing for IMRT

Intensity modulated radiation therapy (IMRT) also known as conformal radiation, delivers radiation with adjusted intensity to preserve adjoining tissue. IMRT has the ability to deliver a higher dose of radiation within the tumor and a lower dose of radiation to surrounding healthy tissue. Two types of IMRT are multi-leaf collimator-based IMRT and, as described below, compensator-based IMRT. IMRT is provided in two treatments phases, planning and delivery.

Hospitals are to bill according to the following guidelines:

- If using 77301 to report IMRT planning services, do not report CPT 77301 with the same line item date of service reported with 77280-77295, 77305-77321, or 77336 if these codes are also billed during a patient course of therapy.
- Hospitals are not prohibited from using IMRT CPT codes 77301 and 77418 to bill for compensator-based IMRT technology in the hospital outpatient setting.
- Payment for IMRT planning does not include payment for CPT codes 77332-77334 when furnished on the same day. When provided, these services are to be billed in

addition to the IMRT planning coded 77301.

- Providers billing for both CPT codes 77301 and 77334 on the same day should append a modifier 59.

Hospital Coding and Billing for Compensator-based IMRT

Compensator-based intensity modulated radiation therapy (IMRT) is a new technology. It is a computer-based method of planning for, and delivery of, narrow, patient-specific, spatially and temporally modulated beams of radiation to solid tumors within a patient.

The computer-based optimization process is referred to as "inverse planning." Inverse planning develops a dose distribution based on the input of specific dose constraints for the planned treatment volume (PTV) and nearby critical structures, and is the beginning of the IMRT treatment process.

When used in a hospital setting, compensator-based IMRT should be billed using 0073T. CMS has defined 0073T (effective Jan. 1, 2005) as compensator-based beam modulation treatment delivery of inverse planned treatment using three or more high resolution (milled or cast) compensators convergent beam modulated fields per treatment session. 0073T is the same assignment as 77418, which is also the delivery of IMRT treatment.

Compensator-based IMRT does not have readily available automatic equivalence to multi-leaf collimator (MLC)-based IMRT, and the physical devices must be changed during the treatment procedure. The reimbursement for 0073T under APC 0412 payment is $336.42. The minimum adjusted copayment is $67.28, and the relative weight unit is 5.4731.

Documentation Requirements for IMRT

The documentation requirement for compensator-based IMRT is the same as for MLC-based. The following summarizes the requirements:

- Each claim must be submitted with an ICD-9-CM code that reflects the condition of the patient and indicates the reasons for the services that were performed. (Claims submitted without an ICD-9-CM code will be returned).
- The reasonable and necessary requirements as outlined under the coverage and limitations sections of the facilities local coverage determination (LCD) (available to the carrier for review upon request).
- The prescription defining the goals and requirements of the treatment plan, including specific dose constraints for the target(s) and nearby critical structures.
- A statement by the treating physician supporting the special need for performing IMRT on the patient in question, rather than performing conventional or 3-dimensional treatment planning and delivery.
- A signed IMRT inverse plan that meets prescribed dose constraints for the planning target volume (PTV) and surrounding normal tissues using either dynamic multi-leaf collimator (DMLC), segmented multi-leaf collimator (SMLC) (average number of "steps" required to meet IMRT delivery is 5), or inverse planned IMRT solid compensators to achieve intensity modulation radiation delivery.

The target verification methodology must include the following documentation:

- The clinical treatment volume (CTV) and the planning target volume (PTV).
- The patient's positioning and immobilization.
- The means of dose verification and secondary means of verification.
- The monitor units (MUs) generated by the IMRT treatment plan, independently checked before the patient's first treatment.
- The fluence distributions re-computed in a phantom.
- An account for structures moving in and out of high- and low-dose regions created by respiration. (Voluntary breath holding is not considered appropriate; immobilization is best accomplished with gating technology.)

Oncology Imaging Reimbursement for 2007

During the past two years Medicare has made significant reimbursement moves that threaten provider return on investment. First, imaging has been targeted for increased claim review based on the belief that inappropriate diagnostic studies are ordered because there has been 27 percent growth in procedures for two

consecutive years. Imaging fees on the physician fee schedule have also been targeted and are scheduled for planned reduction. New imaging technology has seen significant payment reductions in the hospital outpatient (HOPPS) environment as well. Second, ASC (Ambulatory Surgical Center) fees have been categorically reduced to match HOPPS payment in 2007. Over 200 procedure code fees were reduced without any phase-in period.

Hospitals need to think strategically. If you are billing as a freestanding radiation oncology center or you have a joint venture that includes PET, for example, then you will be experiencing reductions in your technical charge reimbursements. Physician and hospital payments are being equalized as seen in the imaging and ambulatory surgical centers and can be expected to be replicated for radiology imaging in the near future.

In February 2007 CMS lowered imaging costs with implementation of a cap on payment, which essentially equals an across-the-board reduction to the technical radiology fees. The new rates are equivalent to the lowest fees paid by Medicare regardless of site of service. Medicare still imposes a 25 percent cut on the technical component of extra scans on contiguous body parts for freestanding centers only. The new rate reductions affect only the technical imaging codes and impact only centers that operate as *freestanding*, since hospital-based centers already receive lower technical payments than freestanding cancer centers.

Other payers have started following Medicare's payment policies. Also, many providers have contracts with private payers that base payments on a percentage of the Medicare allowed rate, so those contracts will take an automatic hit.

The 2007 changes should prepare you for the coming imposition of a Medicare payment scale that is equal for technical charges for all providers. Medicare's policy allows Medicare to pay a provider at the lowest rate Medicare offers *regardless* of the site of service. So, if you have planned your imaging returns on projections of PET/CT rates for practice centers—which are hundreds of dollars more than hospital rates and counted on payers taking forever to catch up—*redo your numbers*. Your risk is much higher than you think, and your return is likely to be lower. It is expected that a flat rate environment is strengthening for radiation oncology, equipment-based new technology, and imaging.

While Medicare is implementing a flat payment level across providers, commercial payers are slowly going back to limiting choice for beneficiaries. More policies are being written that trade restrictive choice for better coverage. The glut of providers offering imaging and new technology enables payers to negotiate lower rates for their patient volume, thus lowering insurers' costs and ultimately reducing your profits. This risk and return problem for providers continues to loom large.

Positron Emission Tomography (PET) Scans and PET/CT

Nonmyocardial PET scans have been moved from APC 1513 *New Technology Level XIII* to C*linically Appropriate* APC 0308. This impacts codes: 78608, 78811, 78812, and 78813. Additionally, PET/CT has been moved from APC 1514 *New Technology Level XIV* to 1511 *New Technology Level XI*. This move affects codes: 78814, 78815, and 78816.

The reasons provided by CMS for moving PET and PET/CT to clinically appropriate APCs are the same. First, new technology APCs are utilized when there is a dearth of claims data that makes it impossible to identify to which clinical APC (existing or new) a procedure belongs. Nonmyocardial PET procedures have at least two years of claims data available, five years at least for some codes, and significant claims data for those with less than two years usage. Second, new technology APCs are used to find the cost differentiation and to develop appropriate reimbursement rates for specific procedures.

The costs for PET procedures have been between $852 and $924 through the period of CY2002 to CY2005. Payment during this time period has been significantly higher, and PET usage has tripled since inception. Since the cost has remained stable through the growth, CMS has moved PET to a *clinical* APC.

Using the same methodology, CMS noted

Table 3. 2007 Stereotactic Treatment Codes, Descriptions, and Payments

HCPCS	Description	2006 APC	2006 Payment	2007 APC	2007 Payment
G0173	Linear accelerator stereotactic radiosurgery, complete	1528	$5,250.00	0067	$3,895.59
G0251	Linear accelerator-based stereotactic radiosurgery	1513	$1,150.00	0065	$1,249.18
G0339	Robot linear accelerator radiosurgery, complete first hour	1528	$5,250.00	0067	$3,895.59
G0340	Robot linear accelerator radiosurgery, fraction treatments 2-5 hours	1525	$3,750.00	0066	$2,644.95

Table 4. 2007 PET and PET/CT APC Codes and Payments

CPT	Description	2006 APC	2006 Payment	2007 APC	2007 Payment
78608	PET, Brain, metabolic evaluation	1513	$1,150.00	0308	$855.43
78811	PET, Tumor, limited	1513	$1,150.00	0308	$855.43
78812	PET, Tumor, skull base to mid-thigh	1513	$1,150.00	0308	$855.43
78813	PET, Tumor, whole body	1513	$1,150.00	0308	$855.43
78814	PET/CT Tumor, limited	1514	$1,250.00	1511	$950.00
78815	PET/CT Tumor, skull base to mid-thigh	1514	$1,250.00	1511	$950.00
78816	PET/CT Tumor, whole body	1514	$1,250.00	1511	$950.00

that PET/CT also had stable cost data with significant volume and that the costs were within $2 of the nonmyocardial PET procedures. Since, there were additional procedures charged for PET/CT and this assignment would bundle those procedures, and since there were only 9 months of available data, CMS assigned PET/CT to a different APC (*New Technology APC 1511*) than nonmyocardial PET, and will continue payment of $100 more for PET/CT services over conventional PET services during 2007. Data will continue to be collected before assigning PET/CT to a clinical APC.

Table 4 summarizes the changes in APC codes for radiology oncology PET and PET/CT for 2007.

Table 5 provides a summary of the Medicare coverage for PET scans as well as those covered under prospective clinical studies.

Whole Body Tumor Imaging

CMS proposed moving CPT code 78804, *radiopharmaceutical localization of tumor distribution of radiopharmaceutical agents; whole body two or more days imaging*, from *New Technology* APC 1508 to *Clinical* APC 0406, *Level I Tumor/Infection Imaging*. After reviewing comments and CY 2005 claims, CMS agreed with commenters that such a move was inappropriate. CMS will maintain differences between single and two-day studies. CMS has developed a new APC, 0408 *Level II Tumor/ Infection Imaging*, for multiple-day imaging and assigned a median cost of $362.05.

Colorectal Cancer Screening

In determining payment for screening colonoscopies, HCPCS codes G0105 *Colorectal cancer screening colonoscopy on individual at risk* and code G0121 *Colorectal cancer screening colonoscopy on individual not meeting criteria for high risk*, CMS evaluated hospitals' median costs. In using this methodology CMS found that the payment rate for hospitals exceeded the payment rate for ambulatory surgery centers (ASC). CMS's final decision on payment for colorectal screening has been set to equal the CY 2007 ASC payment rate of $446.00. Colorectal screening has been added to the list of services for which the beneficiary deductible does not apply.

Table 5. Medicare Coverage for PET Scans

Indication	Covered[1]	Nationally Non-Covered[2]	Covered Under Prospective Clinical Studies[3]
Brain			X
Breast			
Diagnosis		X	
Initial staging of axillary nodes		X	
Evaluation of metastatic disease	X		
Staging of distant metastasis	X		
Restaging,	X		
Monitoring *	X		
Cervical			
Staging as adjunct to conventional imaging	X		
Other staging			X
Diagnosis, restaging, monitoring *	X		
Colorectal			
Diagnosis, staging, restaging	X		
Monitoring *			X
Esophagus			
Diagnosis, staging, restaging	X		
Monitoring *			X
Head and Neck (non-CNS/thyroid)			
Diagnosis, staging, restaging	X		
Monitoring *			X
Lymphoma			
Diagnosis, staging, restaging	X		
Monitoring *			X
Melanoma			
Diagnosis, staging, restaging	X		
Monitoring *			X
Non small cell lung cancer			
Diagnosis, staging, restaging	X		
Monitoring *			X
Ovarian			X
Pancreatic			X
Small cell lung			X
Soft tissue sarcoma			X
Solitary pulmonary nodule (characterization)	X		
Thyroid			
Staging of follicular cell tumors	X		
Restaging of medullary cell tumors			X
All other cancers not listed herein			X

[1] Covered nationally based on evidence of benefit. Refer to National Coverage Determination Manual for specific coverage language and limitations for each indication.
[2] Non-covered nationally based on evidence of harm or no benefit.
[3] Non-covered nationally based on lack of evidence sufficient to establish either benefit or harm, or no prior decision addressing this cancer.
* Monitoring = monitoring response to treatment when a change in therapy is anticipated.

	Policy No:
Insurance Verification Policy	**Approved by:**

Effective Date:	**Page 1 of 2**

I. Policy

To verify that all patients that will be seen at (______________________________) are covered by insurance prior to the delivery of treatment.

II. Scope

This policy applies to all outpatient sites performing chemotherapy and radiation therapy services.

III. Procedure

Following are detailed procedures to be followed when completing an insurance verification form.

1. The financial counselor is responsible for completing the following sections of the insurance verification form at the time all new patients call for an appointment for medical or radiation oncology. Patient's insurance should be re-verified every six months, or when patients notify the office that their insurance coverage has changed.

Patient Name—Complete patient's name in full.

Patient Date of Birth—Enter the patient's birthday.

Date of Appointment—Enter the date of the patient's appointment.

Date Appointment Scheduled—Enter the date that the patient called the office for an appointment.

Scheduled by—Enter the name of the person who scheduled the appointment.

Date—Enter the date that you called the insurance company to verify patient's insurance.

Insurance Name (Primary)—Enter the name of the patient's primary insurance company.

Guarantor—Enter the name of the individual in whose name the insurance is listed.

Relationship—Enter the relationship of the patient to the guarantor (self, spouse, child).

Policy # —Enter the policy number, if applicable, for the primary insurance company.

Group # —Enter the group number, if applicable, for the primary insurance company.

Insurance Name (Secondary)—Enter the name of the patient's secondary insurance company name.

Guarantor—Enter the name of the individual in whose name the insurance is listed.

Relationship—Enter the relationship of the patient to the guarantor (self, spouse, child).

Policy # —Enter the policy number, if applicable, for the secondary insurance company.

Group # —Enter the group number, if applicable, for the secondary insurance company.

2. Once you have completed the insurance verification form with the sections listed above, contact the primary insurance company and verify coverage for the patient. Complete the following sections:

Phone Number—Enter the phone number of the insurance company used to verify patient's insurance.

Contact Person—Enter the name of the person who provided the verification information.

Annual Deductible—Enter the amount of the annual deductible that the patient is responsible for, check the appropriate box and enter any amount left owed by the patient to the right of the boxes.

Precertification Required—Check the appropriate box. If precertification is required, please follow the precertification policy.

Referral Required—Check the appropriate box. If a referral is required, please make sure that the patient is aware that a referral is required. Put a check in the appointment book by the patient's name. When the patient arrives for the appointment, make sure to obtain the referral.

Co-payment Required—Verify that the patient's insurance requires a co-payment, and verify if that co-payment is required for each daily treatment. Enter that amount in the space provided.

3. Once you have verified the primary insurance coverage, contact the secondary insurance company to verify coverage. Complete the following sections:

Phone Number—Enter the phone number of the insurance company used to verify patient's insurance.

Contact Person—Enter the name of the person who provided the verification information.

Annual Deductible—Enter the amount of the annual deductible that the patient is responsible for; check the appropriate box and enter any amount left owed by the patient to the right of the boxes.

Precertification Required—Check the appropriate box. If precertification is required, please follow the precertification policy.

Referral Required—Check the appropriate box. If a referral is required, please make sure that the patient is aware that a referral is required. Put a check in the appointment book and/or computer log by the patient's name. When the patient arrives for the appointment, make sure that he or she presents the referral.

Co-payment Required—Verify that the patient's insurance requires a co-payment, and verify if that co-payment is required for each daily treatment. Enter that amount in the space provided.

4. Once the verification process has been completed, the original copy should be kept in the patient's medical record behind the patient's demographic form.

Under no circumstances should the patient be treated prior to verification of the primary and secondary insurance.

	Policy No:
Treatment Pre-authorization Policy	**Approved by:**
Effective Date:	**Page 1 of 1**

I. Policy

All chemotherapy services must be pre-authorized before any services can be performed.

II. Scope

This policy applies to all outpatient sites performing chemotherapy services.

III. Procedure

Following are detailed procedures to be followed when completing an insurance authorization form:

1. Enter the ordering physician's name.
2. Enter the hospital or group name as assigned by the insurance carrier.
3. Enter the patient's insurance carrier name.
4. Enter the insurance carrier fax number.
5. Enter the patient's insurance ID.
6. Enter the patient's date of birth.
7. Enter the patient's name.
8. Enter the patient's Social Security number.
9. Enter the verbiage for the patient's diagnosis.
10. Enter the corresponding ICD-9 code.
11. Complete the CPT codes for lab tests and enter how often they must be done per the physician order.
12. Complete the HCPCS code, drug name, dose, route and frequency for all premeds.
13. Complete the HCPCS code, drug names, dosages, routes and frequency for any and all hydration medications ordered.
14. Enter the HCPCS code, drug name, dosages, routes and frequency for any and all chemotherapy medications ordered.
15. Enter other information as indicated in the physician orders.
16. Enter HCPCS codes for any and all discharge medications ordered.
17. Enter the treatment start date.
18. Have the ordering physician sign and date the request form.
19. Give the form to the financial counselor.
20. Financial counselor will fax the form to the appropriate insurance carrier.
21. A fax confirmation sheet should be retained for proof request submission.

Allow 24 to 36 hours for a response from the insurance carrier. If you have not received a response within that time frame, follow-up must be done via phone or fax.

Once the authorization has been obtained, the financial counselor will notify the appropriate parties for scheduling purposes.

	Policy No:
Charge Capture Policy	**Approved by:**
Effective Date:	**Page 1 of 1**

I. Policy

To verify that all charge forms are appropriately entered for all outpatient medical oncology services.

II. Scope

This policy applies to all outpatient services delivered by medical oncology nursing staff.

III. Procedure

Following are detailed procedures to be followed initiating and billing for medical oncology services:

1. The reception staff will print a Medical Oncology Encounter Form for each patient the evening prior to the patient's scheduled visit or before the patient is seen.
2. The reception staff will enter all required demographic information, either through the computerized system or by hand.
3. The ICD-9-CM diagnosis information will be left blank and will be completed by the center physician or nursing staff in conjunction with the Medical Records staff.
4. The Encounter Form, with demographic information, will be placed on the outside top cover of the patient chart by paper clip.
5. After the physician has completed the visit, he/she will return the patient chart with the completed Encounter Form to the reception area.
6. The reception staff will batch all of the forms for the day and attach a Medical Oncology Daily Encounter Form Summary.
7. The reception staff will verify that the demographic data are complete for each patient and that each scheduled patient has an Encounter Form or cancellation/no-show status and signs the summary sheet.
8. The reception staff will return the batch to the Nurse for review of the clinical services for accuracy and clinical logic. The Nurse will review, correct as appropriate, and sign the summary sheet. He or she will return the batch to the receptionist.
9. The reception staff will enter charges as recorded for each patient within one day of service using the following rules:
   - All services recorded will be charged.
   - Visit charges for the facility (which are separate from the professional E&M charges) are charged based on specific payer guidelines.
   - Each patient can have only one consultation.
10. Once all of the charges have been entered for a particular day, the manager will print a transaction register from the charge data entry system. The manager will compare the transaction register to the Encounter Forms entered to verify that all charges have been entered prior to closing out the charge batch.
11. After data entry is complete, file the batched Encounter Forms, the Summary Sheet, and the transaction register in the center billing files for reference as needed.

	Policy No:
Claims Billing Policy	**Approved by:**

Effective Date:	**Page 1 of 1**

I. Policy

To ensure that all patients receiving services are billed through the billing system and the appropriate payments are posted.

II. Scope

This policy applies to all sites performing services.

III. Procedure

Following are detailed procedures to be followed when performing the billing function:

1. Once the charges have been entered and a charge audit has been performed, the insurance claims and/or patient statements are ready to be generated.
2. Depending on the billing system, a majority of the insurance claims are sent electronically (Medicare, Blue Shield, Medicaid). Other insurance companies may require paper claims. No less than once per week should your claims be submitted both electronically and manually.

   Patient statements are normally set up to print once per month. Each statement should be reviewed prior to mailing to verify that the appropriate charge and/or payment information has been posted accurately.
3. The claims will go through a sequence of edit checks (billing scrubbers and local medical review policy edits). An error report is generated that provides details as to why the claim has not passed the processing function. The error report is used to make the necessary changes to the claim. It is imperative that the billing department works closely with the cancer center, as the information from the cancer center is crucial to the billing process.
4. Once the claim passes all edits, the claim is then submitted to the insurance company for payment.
5. Once the payer reviews the claim, payment is made via an explanation of benefits (EOB) directly to the hospital for the services rendered. The payment clerk will post the appropriate payments to the patient accounts. The payment clerk will post all the checks, print a copy of the transactions entered into the system, and review that list against the adding machine tape and EOBs to validate that all payments have been entered accordingly. The EOBs, a copy of all checks, and the adding machine tape will be filed in a day file for that day's payments.
6. A review of the EOB happens at the time of payment posting. If the claim is denied, the EOB is passed along to the denial and follow-up representative. If the insurance carrier pays the claim, and there is a balance left, the patient will receive a statement when the appropriate patient statements are printed.
7. If the primary insurance company has paid the claim appropriately, and the patient has a secondary insurance company, the claim is processed to the secondary insurance. A copy of the EOB from the primary insurance is attached to the claim for verification to the secondary insurance carrier.

	Policy No:
Insurance Denial and Follow-up Policy	**Approved by:**
Effective Date:	**Page 1 of 1**

I. Policy

To ensure that all insurance denials are reviewed and processed in a timely manner.

II. Scope

This policy applies to all outpatient sites performing chemotherapy services.

III. Procedure

Following are detailed procedures to be followed when reviewing insurance denials:

1. The billing clerk will meet with the designated patient account representative on a weekly basis to gather the week's denials for the cancer institute.
2. The billing clerk will review the denials with the patient account representative for any appropriate questions.
3. The billing clerk will individually review each insurance company denial and take the necessary action as requested by the carrier:
    - Provide appropriate diagnosis for procedure and/or drug.
    - Provide any additional medical record information as requested by insurance company.
    - Verify if the service is actually non-covered and notify patient accounts representative.
    - Verify the appropriate diagnosis and or procedure code as requested.
4. The billing clerk, with the assistance of the patient account representative, will document on the patient's account any action that was taken to process the denial.
5. The billing clerk will keep a log of the types and number of denials in order to track any inconsistencies that may be occurring in registration, charge entry, or claims submission.
6. Report findings to the appropriate director and patient account representative on a monthly basis.

Appendix II

Medical Oncology Encounter Form

Patient Name: ______________________ Medical Record #: ______________________

Date of Birth: ______________________ Diagnosis Code: ______________________

Identification #: ______________________ Physician Name: ______________________

Social Security #: ______________________ Primary Insurance Carrier: ______________________

Address: ______________________ Policy #: ______________________

Telephone #: ______________________ Secondary Insurance Carrier: ______________________

Case #: ______________________ Policy #: ______________________

Qt	Code	Administration	Qt	Code	Visits
	90760	Hydration iv infusion, initial			(can bill only one service per visit)
	90761	Hydration iv infusion, add-on		99211	Level I Visit, established
	90765	Ther/proph/diag iv inf, init		99212	Level II Visit, established
	90766	Ther/proph/diag iv inf, add-on		99213	Level III Visit, established
	90767	Ther/proph/diag add'l seq iv inf		99214	Level IV Visit, established
	90768	Ther/proph/diag concurrent inf		99215	Level V Visit, established
	90772	Ther/proph/diag inj, sc/im		G0175	Interdisciplinary Team Conference
	90773	Ther/proph/diag inj, ia		99291	Critical Care E&M first 30-74 mins
	90774	Ther/proph/diag inj, iv push			**Vaccine Administration**
	90775	Ther/proph/diag inj add-on		G0008	Vaccine administration, influenza
	90779	Ther/proph/diag inj/inf proc		G0009	Vaccine administration, pneumonia
	96401	Chemo, non-hormonal anti-neopl, sq/im		G0010	Vaccine administration, hepatitis B
	96402	Chemo hormon antineopl sq/im		90472	Immunization admin, each add
	96405	Chemo intralesional, up to 7 lesions		90473	Immune admin oral/nasal
	96406	Chemo intralesional, over 7 lesions		90474	Immune admin oral/nasal addl
	96409	Chemo, iv push, sngl, or init drug			
	96411	Chemo, iv push, add'l drug			**Procedures**
	96413	Chemo, iv infusion, 1 hr			(identify total, can bill multiple units)
	96415	Chemo, iv infusion, add'l hr			Thoracentesis
	96416	Chemo prolong inf w/pump			Paracentesis
	96417	Chemo iv inf each add'l seq			Urinary Cath
	96420	Chemo, ia, push technique			Spinal Punct, Lumbar
	96422	Chemo, ia, inf up to 1 hr			Enema
	96423	Chemo, ia, inf each add'l hr			Pentamidine
	96425	Chemo, ia, prolonged inf with pump			Phlebotomy
	96440	Chemotherapy, pleural cavity, requir thor			Bone Marrow Asp
	96445	Chemotherapy, peritoneal cavity, requir peritan			Bone Marrow Bx
	96450	Chemotherapy, cns (intrathecal) requir spinal puncture			Epidural Inj, Blood Or Clot Patch
	96521	Refill/maint, portable pump			Epidural Inj, Lumbar/Caudal
	96522	Refill/maint implanted pump/resvr syst			Epidural Inj, Thoracic/Cervical
	96523	Irrig drug delivery device			Inj Anesthesia, Cervical
	96542	Chemotherapy, injection			Inj Anesthesia, Occipital Nerve
	96549	Chemotherapy, unspecified			Inj Anesthesia, Intercostal Nerve
	C8957	Prolonged iv inf, regular pump			PICC Line Insert

Radiation Oncology Encounter Form

Patient Name ______________________ Patient Number ______________________

Dates From: __________ To: __________ Outpatient ☐ Inpatient ☐ Hospital ______________

Diagnosis ______________ Restart ☐ Referring M.D. ______________________

Authorization # ______________________ Tx. Physician ______________________

Date	Code	Phys. Initials	Description	Date	Code	MOD	Description	Qty
Outpatient Consults				Simulations				
	99241		Focused		77280		Simple	
	99242		Ext		77285		Intermediate	
	99243		Detail/Mod		77290		Complex	
	99244		Comp/Mod/High		77295		3-D Sim	
	99245		Comp/High		76370		CT Sim	
Inpatient Consults				Physics				
	99251		Focused/Min		77300		Basic Dosim	
	99252		Expand/Low		77300		Basic Dosim	
	99253		Detail Mod		77305		Isodose Sim	
	99254		Comp/Mod/High		77310		Isodose Int	
	99255		Comp/High		77315		Isodose Comp	
			FU Inpt Cons		77321		E Beam Sim	
Follow-up Outpatient/Office					77331		TLD Dosim	
	99211		Min/No Phys		77336		Cont Physics	
	99212		Focus Minor		77370		Special Phys	
	99213		Expnd/Low/Mod		77470		Sp Tx Proc	
	99214		Detail/Mod/Hi	Treatment Devices				
	99215		Comp/High		77332		Simple	
Treatment Planning					77333		Intermediate	
	77261		Simple		77334		Complex	
	77262		Intermediate		77334		Complex	
	77263		Complex		77334		Complex	
	77301		IMRT Tx Plan					

		Day	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Code	Description	Date							
	Daily Treatment Simple								
77403	6-10 MEV								
77404	11-19 MEV								
77406	>20 MEV								
	Daily Treatment Intermediate								
77408	6-10 MEV								
77409	11-19 MEV								
77411	>20 MEV								
	Daily Treatment Complex								
77413	6-10 MEV								
77414	11-19 MEV								
77416	>20 MEV								
77418	IMRT								
77417	Port Film								
77427	Weekly Management								

Date of Last Treatment	Chief Initials	Biller Initials

Association of Community Cancer Centers
11600 Nebel Street, Suite 201
Rockville, MD 20852
301.984.9496
www.accc-cancer.org

Publication and distribution of this booklet were made possible by an educational grant from Amgen Inc.