Capture All of What Oncology Costs Your Practice

Billing relies on documentation to reflect time, resources, and complexity of services accurately.
Oncology practices are continually challenged to gain appropriate reimbursement for services performed, resources used, and drugs dispensed. Let’s address potential billing, coding, and documentation problems where lack of understanding can adversely affect practice revenue.

Recognize Unique Circumstances

A medical oncologist typically will see a cancer patient multiple times throughout the treatment process (beginning with the initial consultation, cancer staging, and care plan coordination), and often for years afterward. An oncologist also might help the patient make the decision to move from treatment to palliative care, coordinating a care plan developed to assure comfort and quality of life.

Due to the complexity of cancer-related cases and the risk involved in treatment, the oncologist’s medical decision-making is typically very high, and the time involved in managing patients is significant. Oncologists often express frustration when faced with coding guidelines that do not seem to reflect the level of services they provide, and may find it difficult to accept that certain follow-up visits with critically (or terminally) ill patients qualify only for a low-level evaluation and management (E/M) service. However, when a patient is in the middle of chemotherapy, and no adverse reactions are reported or no new complaints are noted, the visit would not merit a high level just because there is a cancer diagnosis.

There are, however, situations exclusive to oncology where additional services may be captured and billed, such as adverse reactions to treatment. Appropriate charge capture of these services will ensure that physicians are appropriately compensated for their services during chemotherapy administration.

Physicians should bill codes that accurately reflect the time, resources, and complexity of services they and their staff provide for managing significant adverse drug reactions. Examples of additional billing opportunities for chemotherapy patient management for patients having adverse reactions are:

- When a patient experiences an adverse reaction to drugs during a chemotherapy session that requires physician intervention, you may report an E/M service in addition to the chemotherapy administration services.
- When a patient experiences an adverse reaction to drugs during a chemotherapy session, but had already seen the physician prior to treatment for an unrelated problem, the physician may bill for the significant drug reaction visit. The total time, resources, and complexity of the physician’s interaction with the patient may justify a higher E/M level than the original, separately identifiable E/M service.
- When a patient experiences an adverse reaction to drugs during a chemotherapy session, the physician may be able to bill for prolonged services, depending upon how much time is spent face-to-face with the patient. The encounter must be documented and time clearly noted. Additionally, the physician must spend at least 30 minutes with the patient to justify billing for prolonged services.
- When a patient experiences a life-threatening, adverse reaction to drugs during a chemotherapy session, the physician may be able to bill for critical care services in addition to other services, if the physician’s work involves at least 30 minutes of face-to-face management of the patient’s life-threatening condition.

Example

A patient presents for chemotherapy. Prior to treatment, she sees the oncologist for an assessment of a rash that erupted over her chest following a previous session. The oncologist assesses the rash and prescribes a topical cream. An established patient level 2 E/M (99212 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making.) is charged.

During the subsequent chemotherapy administration, the patient experiences heart palpitations and shortness of breath. The oncologist is called to perform a comprehensive exam of the respiratory and cardiovascular systems, and orders a portable EKG and chest X-ray. Due to the additional provided services beyond the assessment and treatment of the rash, you may now report a level 4 E/M (provided that the additional services are clearly documented).

Capture All Services Rendered

It’s important to accurately and completely document and code chemotherapy administration services, so you also can properly bill for the resources and supplies consumed. Inadequate documentation of these services will inevitably lead to a decrease in revenue, due to claim rejections or denials and missed opportunity.

To ensure your practice is compensated for the services rendered, be sure to address the documentation issues that can result in improper charge capture and billing, such as proper documentation of infusion start and stop times. Without start and stop times, it’s not possible to establish that a drug infusion lasted more than 15 minutes. Infusion services lasting 15 or fewer minutes are reported with intravenous (IV) push codes (96409 Chemotherapy administration; intravenous, push technique, single or initial substance/drug or 96374 Therapeutic, prophylactic, or diagnostic injection (speci-
Infusion services lasting longer than 15 minutes are reported with time-based infusion codes. Start and stop times are required to determine the appropriate concurrent or sequential code assignment, as well as additional billable infusion time beyond the first hour of the infusion. Absent start and stop time documentation will result in the lowest level of chemotherapy administration service being billed.

**Example**

An oncology patient presents for chemotherapy infusion. Documentation indicates that three drugs are administered: vincristine, a chemotherapeutic drug, with a start time of 11:00 a.m.; ondansetron, an anti-emetic, with a start time of 11:15 a.m.; and methotrexate, a chemotherapeutic drug, with a start time of 11:35 a.m. Without clear documentation of the stop times, it’s impossible to determine the appropriate CPT® code assignments. From an auditing perspective, it’s assumed that all three drugs were administered in less than 15 minutes, and IV push codes would be assigned.

- **96409** - for the initial IV push
- **+96375** - Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of a new substance/drug (List separately in addition to code for primary procedure) for additional sequential IV push of a new substance
- **+96411** - Chemotherapy administration; intravenous, push technique, each additional substanceldrug (List separately in addition to code for primary procedure) for additional chemotherapeutic substance/drug, IV push technique.

The same example, with stop times, is:

- Vincristine start 11:00 a.m., stop 11:10 a.m. - 96409
- Ondansetron start 11:15 a.m., stop 11:35 a.m. - +96367 Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); additional sequential infusion of a new drug/substance, up to 1 hour (List separately in addition to code for primary procedure)
- Methotrexate start 11:35 a.m., stop 12:30 p.m. - +96417 Chemotherapy administration, intravenous infusion technique; each additional sequential infusion (different substance/drug), up to 1 hour (List separately in addition to code for primary procedure)

**Billing Anemia as a Side Effect**

Anemia, a common side effect of chemotherapy, must be treated during the course of therapy. The provider should document the specific type of anemia to meet medical necessity requirements when billing for anemia drugs during the course of treatment. In addition to the infusion and injection codes, the claim form must include the proper HCPCS Level II code for the anemia drug administered and a minimum of two ICD-9-CM codes: one for the anemia, and one or more for the underlying condition that caused the anemia.

The exception to this rule is antineoplastic chemotherapy induced anemia, which has its own code, 285.3 Antineoplastic chemotherapy induced anemia. Always check your local coverage determinations (LCDs), and national coverage determinations (NCDs) for updated medical necessity guidelines related to anemia due to chemotherapy.

**Examples**

- A patient undergoing chemotherapy is diagnosed with “anemia induced by chemotherapy.” ICD-9-CM coding is 285.3. This code does not require an E code because the source of the anemia is named as the cause in the description of the code. This is usually a short-term anemia, and isn’t considered aplastic.
- A patient undergoing chemotherapy is diagnosed with “aplastic anemia due to chemotherapy.” ICD-9-CM coding is 284.89 Other specified aplastic anemias. An E code from the Table of Drugs and Chemicals is required to specify the drug that is the source of the anemia.
- A cancer patient is diagnosed with “anemia due to a neoplastic disease.” ICD-9-CM coding is 285.22 Anemia in neoplastic disease. In this case, the source of the anemia is the disease, not the treatment of the neoplasm.
Oncology

Charge Capture of Correct Units
If chemotherapy drugs are hard-coded into a charge description master (CDM) or fee schedule, cross check the administered chemotherapy drug units against how that drug is set up in the office billing system. The maximum allowable fee per unit is based on the HCPCS Level II description of the chemotherapy drug. Errors are often made and drugs are frequently under-billed because they are hard coded with a unit of one.

Example: For single-dose vials, bill the total amount of the drug contained in the vial(s), including partial vials. Based on the unit definition for the HCPCS Level II code, reimbursement is made based upon the total number of units contained in the vial.

Multiple units also may be billed over the course of a treatment, or over the course of a single day. It’s important not only to capture multiple units per day, but also multiple units per treatment.

Example: A patient may receive up to 275 mg of epirubicin HCI per day, but the HCPCS Level II code (J9178 Injection, epirubicin HCI, 2 mg) used to report the drug only covers 2 mg. This is why it’s very important that the proper number of units be documented, captured, and billed.

CDMs and fee schedules should be reviewed annually to ensure that the line items and units accurately reflect the HCPCS Level II descriptions. Training and education for clinicians and technicians is imperative to ensure proper charge capture. Implement ongoing auditing and monitoring to identify and remediate systemic issues before they result in long-term revenue losses. HBM

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