REVENUE CYCLE CODING STRATEGIES®

Navigator® for Medical Oncology, Hematology and Infusion Centers 2022 Edition

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2 Medicare Program Overview

The Centers for Medicare & Medicaid Services, commonly referred to as CMS, is the agency that manages Medicare and provides healthcare coverage for a certain demographic of people. The payment system constructs and publishes guidelines for coverage and reimbursement and are typically used as a guideline for other commercial payer entities when establishing coverage and reimbursement. It is not uncommon for a commercial or private payer to include coverage and reimbursement guidelines stricter or varied from CMS. Additionally, even though Medicare has beneficiaries in all 50 states, Puerto Rico and Guam, the coverage, guidelines and reimbursement for some designated services may vary between the jurisdictions under the direction of each assigned Medicare Administrative Contractor (MAC).

The payment systems utilized by CMS, typically referred to as Part A and Part B, will also reflect differences in how services are reimbursed or guidelines for billing and coverage, even within the same jurisdiction overseen by the same Medicare Administrative Contractor. Due to this, it is imperative that any provider or entity review the guidelines as they pertain to their specific setting and geographic location. It is possible the reimbursement and guidelines may be different from another similar entity; however, both be correct based on the location and type of facility.

The Revenue Cycle Coding Strategies *Navigator® for Medical Oncology, Hematology and Infusion Centers* will review relevant Authoritative Guidance from CMS as well as include, where appropriate, information from the American Medical Association (AMA), *Federal Register* and American Hospital Association (AHA).

Medicare Payment Systems

There are multiple payment systems within the Medicare program; this section will focus on the Medicare Physician Fee Schedule (MPFS) and the Hospital Outpatient Prospective Payment System (HOPPS) only.

Medicare Physician Fee Schedule (MPFS)

The Centers for Medicare and Medicaid Services (CMS) utilizes the Medicare Physician Fee Schedule (MPFS) to reimburse physicians and office settings for services provided to Medicare beneficiaries. Historically, MPFS payment rates have been based on three key factors: relative value units (RVUs), geographic practice cost indexes (GPCIs) and the conversion factor (CF).

Relative Value Units (RVUs) are assigned to all Current Procedural Terminology (CPT®) codes; RVUs are based on resource costs associated with physician work, practice expense and professional liability insurance. The assigned RVUs are adjusted by GPCIs, which reflect the variances in practice costs for locations throughout the country; essentially, how the cost of living impacts business costs. The Conversion Factor (CF) is a scaling factor used to convert the geographically adjusted RVUs into dollar amounts. On April 16, 2015, H.R.2, when the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) became law, significant changes were made to the CF.

Beginning in CY 2020, the conversion factor no longer played the key role it has played in determining the swing from year-to-year in reimbursement changes under MPFS. This is due to changes outlined under MACRA. Starting in CY 2020, the CF was set at the CY 2019 rate and reimbursements based on performance measures under the Merit-based Incentive Payment System (MIPS).

Beginning in 2026, CF rates will be based on participation in Advanced Alternative Payment Models (APMs). Qualifying APM participants will see a 0.75% increase to the CF and non-qualifying APM participants will only receive 0.25% increase to the CF. Additional changes to the RVUs and/or inclusion of a budget neutrality factor will continue to influence overall reimbursement each year.

Formulas are used to calculate non-facility and facility rates. Non-facility rates apply to services performed in office settings, while facility rates apply to physicians providing services in hospital departments and ambulatory surgical centers. Facility rates for evaluation and management codes are typically lower than non-facility rates as the physician providing the service does not have the expense associated with the technical component of the procedure. Physicians billing professional services performed in freestanding facilities, physician offices and hospital departments are reimbursed under the MPFS and will submit claims on a CMS 1500.

MPFS Status Indicators

The MPFS assigns a status indicator to each procedure code to explain if and how it is paid. The table below shows the status indicators relevant to oncology. A complete listing and full definitions are included in Addendum A to the MPFS Final Rule.

Status Indicator	Procedure Code Is:
A	Active code, paid separately if covered
B	Bundled, never paid separately
C	Contractor-priced; contractor determines RVUs and pricing
N	Noncovered, never paid by Medicare
R	Subject to restricted coverage
T	Paid only if no other payable service is billed on the same date
X	Excluded by statute, never paid separately

Hospital Outpatient Prospective Payment System (HOPPS)

Medicare pays hospitals for most services under two different prospective payment systems. Under a prospective payment system, the hospital receives a fixed reimbursement amount for each patient in a defined category, rather than a variable amount that is based on the hospital's use of resources for each individual patient.

The Hospital Outpatient Prospective Payment System (HOPPS) is the route through which hospital outpatient departments are reimbursed for services provided to Medicare beneficiaries. Services reimbursed under HOPPS are assigned an Ambulatory Payment Classification (APC) with multiple CPT® or Healthcare Common Procedure Coding System (HCPCS) codes receiving the same APC designation. Services considered similar from both a clinical and resource aspect may be placed in a single APC.

Each APC is assigned a relative weight factor, which is used to calculate the national unadjusted payment rate, based on the median cost of the individual services in the APC. A portion of this payment rate (60%) is attributed to labor and is adjusted to reflect geographic wage variations using the hospital wage index. The APC payment rates, not paid entirely by Medicare, are assigned coinsurance amounts for most procedures. All procedures performed on Medicare beneficiaries in hospital outpatient departments are paid under this payment system and claims are submitted on UB04 forms.

Under the Inpatient Prospective Payment System (IPPS), hospitals are paid for inpatient services based on Diagnosis-Related Groups (DRGs). For each inpatient admission, the hospital receives a single DRG payment that is determined by the ICD-10 diagnosis and procedure codes the hospital submits on the claim. Hospitals do not use CPT® codes for inpatient billing.

As apparent from the information above, there is no comparison between the MPFS and HOPPS/IPPS payment systems. The CMS website has information regarding both payment systems discussed in this chapter and can be found at:

www.cms.hhs.gov

OPPS Status Indicators

CMS assigns a status indicator to each procedure code to show when and how it is paid under OPPS. The following table shows the status indicators that may apply to oncology services. For a complete listing of status indicators, and for full status indicator definitions, see Addendum D1 of the OPPS Final Rule, available on the CMS website at:

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices

7 Drug Administration

Drugs and biologicals may be administered in the patient's home, in the physician's office, in a clinic, in a hospital outpatient department or as an inpatient. The frequency and duration of treatment depends primarily on the disease or condition being treated and the drugs to be delivered. Numerous administration codes are available for use depending on the drug or biological administered and are divided into three separate categories to include:

- Chemotherapy and other highly complex drugs or biological agents
- Therapeutic, prophylactic and diagnostic
- Hydration

CPT® instructs, the term "chemotherapy" includes highly complex drugs and biological agents, and requires additional physician and staff monitoring due to the potential for adverse reactions. The chemotherapy administration codes are utilized for administration of non-radionuclide anti-neoplastic drugs, as well as anti-neoplastic drugs administered for non-cancerous diagnoses, such as auto-immune diseases. This also includes monoclonal antibodies and biological response modifiers.

Specific to biological response modifiers, some payers have provided additional clarification regarding appropriate administration coding. The following information is instructed by Medicare Administrative Contractor First Coast Service Options, Inc. within the *"Administration of Certain Biological Response Modifiers"* article.

> "Biological response modifiers (BRMs) are agents that modify the relationship between microorganisms and hosts by changing the host's biological response resulting in a desired therapeutic effect.

BRMs are also referred to as immunotherapy or immune therapy. First Coast Service Options, Inc. (FCSO) will allow the use of chemotherapy administration codes for certain BRMs when it is evident that requirements are demonstrated as specified in the CPT description for chemotherapy administration codes. It should be documented that the administration of the BRM requires advanced practice, training and competency of the staff that provide the service; special considerations for preparation, dosage or disposal; and significant patient risk, which requires frequent monitoring.

Currently, FCSO considers the following BRMs for payment using a chemotherapy administration code:

- Monoclonal antibodies
- Interleukins
- Tumor necrosis factors
- Certain fusion proteins

Payment of a chemotherapy administration code will not be allowed when administering the following (not an all inclusive list):

- Colony stimulating factors
- Nesiritide
- Erythroid stimulating agents (EPO, DPA, etc.)
- Vaccines
- Leucovorin
- Immunoglobulins, IVIG
- Growth Factors
- Steroids
- Vitamins"

Therapeutic and prophylactic administration codes are utilized for the administration of medications, such as antibiotics, antiemetics, analgesics, narcotics and