



FLORIDA SOCIETY OF CLINICAL ONCOLOGY FAX BLAST – January 9, 2008

CLINICAL PRACTICE COMMITTEE: Thomas Gaddis, MD, Chairman

Oncotype DX® Added to NCCN Guidelines (01/04/2008)

A recommendation for use of the Oncotype DX® test has been added to the 2008 breast cancer treatment guidelines from the National Comprehensive Cancer Network (NCCN). According to the guidelines, Oncotype DX may be used to guide chemotherapy decisions among certain women with node-negative, hormone receptor-positive, HER2-negative breast cancer.

Hydration with Chemotherapy

We have been receiving several questions regarding Hydration with Chemotherapy. Perhaps the response from ASCO below will be helpful in regard to Medicare **Part B**. - **ISSUE:** Can anyone please share with me how they are billing for hydration and chemotherapy done on the same day?

RESPONSE: (Pertains to Medicare Part B)

A staff member who assisted with ASCO's Coding & Reimbursement Hotline responded as follows: According to the Medicare guidelines, and the Medicare NCD, separate payment is made for hydration therapy provided sequentially (but not concurrently) to the chemotherapy infusion. Other payers may have different guidelines, however, and you may want to touch base with them directly.

When billing Medicare, to indicate that hydration was administered sequentially, that is, before or after chemotherapy, report 90761 to identify hydration was not furnished concurrent with chemotherapy. The 59 modifier should be added to the hydration administration code to indicate that the hydration occurred before or after the chemotherapy administration. Code 90761, each additional hour of hydration, can be used to report hydration services lasting 30 minutes or longer that are secondary or subsequent to another *initial* service. (The *initial* service would be an administration service.)

One code in each category of drug administration has been designated as the “initial” service. The initial codes are 90760 (for hydration), 90765 (for therapeutic and diagnostic infusions), 90774 (for therapeutic and diagnostic pushes), 96409 (for chemotherapy pushes), and 96413 (for chemotherapy infusions). Only one initial service code should be reported per patient encounter. It is not necessary to report an initial service code from each category of drug administration when services are being reported. The initial code that best describes the service being performed that day should be reported. The initial code does not have to correspond to the first service performed. For example, if you perform hydration and chemotherapy infusion on the same day and the chemotherapy infusion is the key service, the initial code for chemotherapy infusion (96413) should be billed even if the hydration was performed prior to the chemotherapy infusion.

Again, as stated above, the hydration service would be reported using the “each additional” hydration code, CPT 90761, instead of 90760. The initial hour of hydration is not used because hydration does not accurately describe the key service performed. The -59 modifier is used to indicate that hydration is performed prior to the chemotherapy infusion (if performed concurrently, then it would not be separately billable).

FCSO Claim Denials for 96523

The CPC has also been looking into the denials for 96523 (irrigation of a venous access device) when billed with J1642 (heparin). These are the only services being billed and it is not a “bundled” service. It appears this issue might be a result of edits which will not allow 96523 to be billed with a J Code as well. FCSO is aware of the problem and is looking for a fix. In the meantime, if you have denied claims for this situation, you should begin the appeals process now and hopefully the issue will be resolved soon.

BLUE CROSS/BLUE SHIELD OF FLORIDA:

Several practices have indicated they have been having reimbursement issues. After contacting BCBS below are some tips that may help your practice in 2008 if you receive denials:

- Contact the Network Management Service Unit (1-800-727-2227, Option 4, Option 2) to verify that each provider in the group has their NPI numbers in the BCBS system for each provider. This call center can assist with researching each provider and educate them on what information is required- such as the NPI form on the website (www.bcbsfl.com) (under forms.)
- If your NPI number has not been sent and loaded into the BCBSF system and you submit a claim with only the NPI number, the claim will deny.
- When filing to BCBS always **file with the BCBS of Florida provider number** (not the Medicare # and not the UPIN number). The pay to provider should be in block 33 and the rendering in 24J. If you are using NPI numbers-you need to verify all numbers have been sent to BCBS.
- Another helpful hint is for you to file claims with unlisted drugs on paper. If you file these claims electronically- they will deny every time asking for the NDC number.
- If you have a member on a consistent regimen with the same drugs, most of the time BCBS can add controls for these types of situations where the member is receiving weekly treatment so that medical records are not requested on every claim. However, this is only for BCBSF members. Other Blue Plans, FEP and State have their own guidelines
- For any out of state claim issues- they have to be handled case by case. Each state has their medical coverage guidelines.

Regarding other issues with medical records. Most issues are associated with the State and Federal members- it is their policy for BCBS of FL to hold any claim with billed charges in **excess of \$5,000**. Records will have to be sent on each claim. They are self- insured accounts and BCBS only administers their benefit plan as they request it to be administered.

CMS UPDATES:

2008 Fee Schedule Update:

The following is an update to the original message that was sent on Monday, December 31, 2007. This update includes additional information regarding the posting of new fee schedule amounts on Medicare Contractor websites. (**Updated information is italicized.**)

The Medicare, Medicaid and SCHIP Extension Act of 2007 made several changes affecting payments to physicians. One such change provides for a 0.5 percent increase to the Medicare Physician Fee Schedule (MPFS) conversion factor for dates of service beginning **January 1 through June 30, 2008**, instead of the (negative) -10.1 percent that was scheduled to take place. Effective for dates of service on and after **July 1, 2008**, the (negative) -10.1 percent update to the physician fee schedule will go into effect. First Coast Service Options (FL Medicare Carrier) **has been instructed to be ready to process claims with January 2008 dates of service with the new fees beginning January 7, 2008.**

The new fees are expected to be posted on the FCSO website no later than January 11, 2008. The "Medicare Physician Fee Schedule Look-Up" link on the Centers for Medicare & Medicaid Services (CMS) Website, which allows you to customize your search, will be updated with the new 2008 fees during the week of January 21, 2008. However, the carrier specific public use files are available now on the CMS Website for the new 2008 MPFS rates at the following link: <http://www.cms.hhs.gov/PhysicianFeeSched/PFSCSF/list.asp>

DRUG AND INDUSTRY UPDATES:

New Studies on Anemia Drugs' Risks

FDA is reviewing new data from two studies that provide further evidence of the risks of ESAs. These two studies were not among the six described in the revised labeling that was approved by FDA on Nov. 8, 2007, which strengthened warnings about ESAs in cancer patients. All eight studies together show more rapid tumor growth or shortened survival

for patients with breast, non-small cell lung, head and neck, lymphoid or cervical cancers that received ESAs, compared to those patients who did not receive the treatment. Additional action may be taken. In the meantime, the FDA recommends that health care providers review the risks and benefits of ESAs outlined in the product label and discuss this information with their patients. FDA plans to discuss this new data and revisit the risks and benefits of using ESAs in patients with chemotherapy-induced anemia at a public advisory committee meeting in the next few months.

ASCO UPDATES:

NGS Medicare ESA Local Coverage Policy (LCD) Update

National Government Services has updated their Local Coverage Policy (LCD) for Erythropoietin Stimulating Agents (ESAs), L25211, which became effective on 1/1/2008. NGS has added in some documentation requirements (see below), among other changes.

*For patients on ESA therapy for MDS (initiated prior to 12/01/2007), National Government Services requires a physician's formal statement that, "the patient does have MDS", be included in the medical record.

*For ESA therapy (initiated on or after 12/01/2007), a copy of the actual bone marrow report must be included in the medical record. MDS cannot be diagnosed definitively until a bone marrow biopsy is performed to confirm the diagnosis.

2008 PQRI Program

ASCO will be hosting a national audio-conference call (Scheduled for 1/9/2008) on "Adapting to Changes" in Medicare for 2008 that will provide further instructions to assist members in the implementation of the 2008 Physicians Quality Reporting Initiative program, and other changes. More information on the audio-call can be found in the News and Notes section at www.asco.org/pqri.

FCSO UPDATES:

Part A EMC Claims Rejected Incorrectly on January 2, 2008

Claims received on or after January 1, 2008, may have been rejected if there was no NPI information for the secondary provider. The reject code given is "99 BILL/ATT/OPER/OTH NPI REQD." The error was the result of an incorrect setup of NPI logic related to the January release changes. This issue has been corrected by FCSO. Therefore, no action will be required on the part of the submitter. However, to recover the improperly rejected claims, all files received on January 1 and 2 must be reloaded into the system. Once this occurs, you need to know the following:

If your claims were rejected in error, they will be reprocessed when the EMC files are reloaded. If your claims were accepted (not affected by the error), a duplicate claim will be created when the recovered EMC files are reloaded that will cause the claim to fail a FISS duplicate reason code. No Action Required by EDI Submitters. Affected claims will be recovered and processed with the January 4, 2008, cycle.

CORPORATE MEMBERSHIP/SPONSORSHIP: (January 1 – December 31, 2008)

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FLASCO EVENTS:

January 19, 2008 – 4th Annual Clinical Breakthroughs & Challenges In Hematologic Malignancies- Disney's Grand Floridian Resort & Spa, Lake Buena Vista

March 7-8, 2008 – FLASCO Spring Meeting – Tampa Airport Marriott Hotel

November 7-8, 2008 – FLASCO Fall Meeting – Tampa Airport Marriott Hotel

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