

Coding For Practices

by Barbara Constable, MBA, RN

Here's what oncology practices need to know about the 2006 Physician Fee Schedule that went into effect Jan. 1, 2006.

Q. *Is CMS continuing its demonstration project for oncology practices in 2006?*

A. In the 2006 Physician Fee Schedule, CMS extended the cancer quality (chemotherapy) demonstration project but with *major* revisions. In its original form, the patient outcome data demonstration project effectively ended on Dec. 31, 2005. Starting Jan. 1, this "revised" project *only applies* to office-based oncologists and hematologists who provide level 2-5 evaluation and management (E&M) services to beneficiaries with these primary diagnoses:

- Breast cancer (invasive)
- Colon cancer
- Rectal cancer
- Prostate cancer
- Lung cancer (either non-small cell or small cell)
- Stomach cancer
- Esophageal cancer
- Pancreatic cancer
- Ovarian cancer
- Non-Hodgkins lymphoma
- Chronic myelogenous leukemia
- Multiple myeloma
- Cancer of the head and neck.

During the E&M visit, physicians must submit one G-code from each of three categories in order to receive an additional \$23 payment. The first category, primary focus of the E&M visit, is associated with 6 new G-codes (G9050 through G9055). Seven new G-codes (G9056 through G9062) will be used with the second category, practice guide-

line adherence. The third category, current disease site, is associated with 68 new G-codes (G9063 through G9129). A list of all the new codes is available on ACCC's website at: www.accc-cancer.org.

Q. *What is the conversion factor and how does it affect my reimbursement?*

A. The conversion factor for CY2006 is \$36.1770, which is 4.4 percent lower than the CY2005 conversion factor of \$37.8975. Calculated by the Office of the Actuary, the conversion factor is updated annually for inflation. The conversion factor is the multiplier that converts payment to dollar amounts. Because the conversion factor changes yearly to keep within the overall Medicare budget, it directly affects our bottom line.

Q. *Why is there an additional \$69 payment for IVIG, and what code is used to report it?*

A. In 2006, CMS created a temporary add-on payment to cover the additional pre-administration related services required to locate and acquire adequate IVIG products and prepare for the infusion. This code was established because inconsistent availability and the multiple varieties of available IVIG have made it very difficult for physicians to obtain the product or a specific brand of product for patients. CMS found that many of the IVIG products previously available in 2005 have been discontinued and are being replaced by new products.

Starting Jan. 1, practices should bill the temporary G-code G0332 (pre-administration related

services for intravenous infusion of immunoglobulin, per infusion encounter)

in conjunction with administration of immunoglobulin. This G-code can only be billed *once* per day in association with patient administration. The G-code is also used in the hospital outpatient setting.

Q. *What codes should I use when reporting a follow-up consult visit?*

A. Effective Jan. 1, 2006, inpatient consult codes 99261 through 99263 and confirmatory consult codes 99271 through 99275 were deleted. The office/outpatient consults 99241 through 99245 and initial inpatient consults 99251 through 99255 have remained the same. The initial inpatient consult code should be used once per admission. Follow-up visits should be reported using 99231 through 99233.

Q. *Are there any important administration code payment changes my practice should be aware of?*

A. There are 33 codes for administration in 2006. Two new codes have been added that did not have temporary or CPT codes assigned last year: 90779 (unlisted therapeutic, prophylactic or diagnostic intravenous or intra-arterial injection or infusion) and 96423. (96423 is an add-on code for chemotherapy administration, intra-arterial; infusion technique, each additional hour up to 8 hours. List 96423 separately in addition to the code for the primary procedure.)

Remember that preparation, starting of the infusion, discontinuing of the infusion, and any related flushing of devices along with supplies used are included in the service payment provided and are *not* reported separately. 📌

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