2018
Oncology/Hematology
A comprehensive illustrated guide to coding and reimbursement

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Getting Started with Coding Companion

Coding Companion for Oncology/Hematology is designed to be a guide to the specialty procedures classified in the CPT® book. It is structured to help coders understand procedures and translate physician narrative into correct CPT codes by combining many clinical resources into one, easy-to-use source book.

The book also allows coders to validate the intended code selection by providing an easy-to-understand explanation of the procedure and associated conditions or indications for performing the various procedures. As a result, data quality and reimbursement will be improved by providing code-specific clinical information and helpful tips regarding the coding of procedures.

For ease of use, Coding Companion lists the CPT codes in ascending numeric order. Included in the code set are all surgery, radiology, laboratory, medicine, and evaluation and management (E/M) codes pertinent to the specialty. Each CPT code is followed by its official CPT code description.

Resequecing of CPT Codes
The American Medical Association (AMA) employs a resequenced numbering methodology. According to the AMA, there are instances where a new code is needed within an existing grouping of codes, but an unused code number is not available to keep the range sequential. In the instance where the existing codes were not changed or had only minimal changes, the AMA assigned a code out of numeric sequence with the other related codes being grouped together. The resequenced codes and their descriptions have been placed with their related codes, out of numeric sequence.

CPT codes within the Optum360 Coding Companion series display in their resequenced order. Resequenced codes are enclosed in brackets for easy identification.

ICD-10-CM
Overall, the 10th revision goes into greater clinical detail than did ICD-9-CM and addresses information about previously classified diseases, as well as those diseases discovered since the last revision. Conditions are grouped with general epidemiological purposes and the evaluation of health care in mind. New features have been added, and conditions have been reorganized, although the format and conventions of the classification remain unchanged for the most part.

Detailed Code Information
One or more columns are dedicated to each procedure or service or to a series of similar procedures/services. Following the specific CPT code and its narrative, is a combination of features. A sample is shown on page ii. The black boxes with numbers in them correspond to the information on the page following the sample.

Appendix Codes and Descriptions
Some CPT codes are presented in a less comprehensive format in the appendix. The CPT codes appropriate to the specialty are included in the appendix with the official CPT code description. The codes are presented in numeric order, and each code is followed by an easy-to-understand lay description of the procedure.

The codes in the appendix are presented in the following order:
- Category III
- Radiology
- Pathology and Laboratory
- Medicine Services

Category II codes are not published in this book. Refer to the CPT book for code descriptions.

CCI Edit Updates
The Coding Companion series includes the list of codes from the official Centers for Medicare and Medicaid Services' National Correct Coding Policy Manual for Part B Medicare Contractors that are considered to be an integral part of the comprehensive code or mutually exclusive of it and should not be reported separately. The codes in the Correct Coding Initiative (CCI) section are from version 22.3, the most current version available at press time. The CCI edits are located in a section at the back of the book. Optum360 maintains a website to accompany the Coding Companions series and posts updated CCI edits on this website so that current information is available before the next edition. The website address is http://www.optum360coding.com/ProductUpdates/. The 2017 edition password is: SPEC17DLC. Please note that you should log in each quarter to ensure you receive the most current updates. An email reminder will also be sent to you to let you know when the updates are available.

Evaluation and Management
This resource provides documentation guidelines and tables showing evaluation and management (E/M) codes for different levels of care. The components that should be considered when selecting an E/M code are also indicated.

Index
A comprehensive index is provided for easy access to the codes. The index entries have several axes. A code can be looked up by its procedural name or by the diagnoses commonly associated with it. Codes are also indexed anatomically. For example:

- Mastoid
  - 69501 Transmastoid antrotomy (simple mastoidectomy)

could be found in the index under the following main terms:

- Antrotomy
- Transmastoid, 69501
- Excision
- Mastoid
- Simple, 69501

General Guidelines

Providers
The AMA advises coders that while a particular service or procedure may be assigned to a specific section, the service or procedure itself is not limited to use only by that specialty group (see paragraphs two and three under “Instructions for Use of the CPT Codebook” on page xii of the CPT Book). Additionally, the procedures and services listed throughout the book are for use by any qualified physician or other qualified health care professional or entity (e.g., hospitals, laboratories, or home health agencies). Keep in mind that there may be other policies or guidance that can affect who may report a specific service.

Supplies
Some payers may allow physicians to separately report drugs and other supplies when reporting the place of service as office or other nonfacility setting. Drugs and supplies are to be reported by the facility only when performed in a facility setting.

Professional and Technical Component
Radiology and some pathology codes have a technical and a professional component. When physicians do not own their own equipment and send their patients to outside testing facilities, they should append modifier 26 to the procedural code to indicate they performed only the professional component.
Chemotherapy administration, into CNS (eg, intrathecal), requiring and including spinal puncture (96450)

Explanation
The physician or supervised assistant prepares and administers a chemotherapeutic medication to combat malignant neoplasms or microorganisms. This code applies to medication injected into the spinal cord through a catheter placed through the space between the lower back bones (lumbar puncture).

Coding Tips
For refilling and maintenance of a portable pump or implantable infusion pump/reservoir, see 96521–96523. For intravesical chemotherapy administration, see 51720. For insertion of a subarachnoid catheter and reservoir for drug infusion, see 62350, 62351, and 62360–62362. For insertion of an intraventricular catheter and reservoir, see 61210 and 61215. Medicare and some other payers may require HCPCS Level II code Q0083, Q0084, or Q0085 be reported for this service.

ICD-10-CM Diagnostic Codes
- C70.0 Malignant neoplasm of cerebral meninges
- C70.1 Malignant neoplasm of spinal meninges
- C71.0 Malignant neoplasm of cerebrum, except lobes and ventricles
- C71.1 Malignant neoplasm of frontal lobe
- C71.2 Malignant neoplasm of temporal lobe
- C71.3 Malignant neoplasm of parietal lobe
- C71.4 Malignant neoplasm of occipital lobe
- C71.5 Malignant neoplasm of cerebral ventricle
- C71.6 Malignant neoplasm of cerebellum
- C71.7 Malignant neoplasm of brain stem
- C71.8 Malignant neoplasm of overlapping sites of brain
- C72.0 Malignant neoplasm of spinal cord
- C72.1 Malignant neoplasm of cauda equina
- C79.31 Secondary malignant neoplasm of brain

Terms To Know
- catheter: Flexible tube inserted into an area of the body for introducing or withdrawing fluid.
- chemotherapy: Treatment of disease, especially cancerous conditions, using chemical agents.
- injection: Forcing a liquid substance into a body part such as a joint or muscle.

Medicare Edits

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HCPCS Equivalent Codes
- Q0083 Chemotherapy administration by other than infusion technique only (e.g., subcutaneous, intramuscular, push), per visit
- Q0084 Chemotherapy administration by infusion technique only, per visit
- Q0085 Chemotherapy administration by both infusion technique and other technique(s) (e.g., subcutaneous, intramuscular, push), per visit

Medicare Reference

Modifiers

| 96450 | N/A | N/A | 80* |

* with documentation

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Evaluation and Management

This section provides an overview of evaluation and management (E/M) services, tables that identify the documentation elements associated with each code, and the federal documentation guidelines with emphasis on the 1997 exam guidelines. This set of guidelines represent the most complete discussion of the elements of the currently accepted versions. The 1997 version identifies both general multi-system physical examinations and single-system examinations, but providers may also use the original 1995 version of the E/M guidelines; both are currently supported by the Centers for Medicare and Medicaid Services (CMS) for audit purposes.

The levels of E/M services define the wide variations in skill, effort, and time and are required for preventing and/or diagnosing and treating illness or injury, and promoting optimal health. These codes are intended to represent physician work, and because much of this work involves the amount of training, experience, expertise, and knowledge that a provider may employ when treating a given patient, the true indications of the level of this work may be difficult to recognize without some explanation.

At first glance, selecting an E/M code may appear to be difficult, but the system of coding clinical visits may be mastered once the requirements for code selection are learned and used.

Providers

The AMA advises coders that while a particular service or procedure may be assigned to a specific section, the service or procedure itself is not limited to use only by that specialty group (see paragraphs 2 and 3 under “Instructions for Use of the CPT® Codebook” on page xii of the CPT Book). Additionally, the procedures and services listed throughout the book are for use by any qualified physician or other qualified health care professional or entity (e.g., hospitals, laboratories, or home health agencies).

The use of the phrase “physician or other qualified health care professional” (OQHCP) was adopted to identify a health care provider other than a physician. This type of provider is further described in CPT as an individual “qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable):” State licensure guidelines determine the scope of practice and a qualified health care professional must practice within these guidelines, even if more restrictive than the CPT guidelines. The qualified health care professional may report services independently or under incident-to guidelines. The professionals within this definition are separate from “clinical staff” and are able to practice independently. CPT defines clinical staff as “a person who works under the supervision of a physician or other qualified health care professional and who is allowed, by law, regulation, and facility policy to perform or assist in the performance of a specified professional service, but who does not individually report that professional service.” Keep in mind that there may be other policies or guidance that can affect who may report a specific service.

Types of E/M Services

When approaching E/M, the first choice that a provider must make is what type of code to use. The following tables outline the E/M codes for different levels of care for:

- Office or other outpatient services—new patient
- Office or other outpatient services—established patient
- Hospital observation services—initial care, subsequent, and discharge
- Hospital inpatient services—initial care, subsequent, and discharge
- Observation or inpatient care (including admission and discharge services)
- Consultations—office or other outpatient
- Consultations—inpatient
- Emergency department services
- Critical care
- Nursing facility—initial services
- Nursing facility—subsequent services
- Nursing facility—discharge and annual assessment
- Domiciliary, rest home, or custodial care—new patient
- Domiciliary, rest home, or custodial care—established patient
- Home services—new patient
- Home services—established patient
- Newborn care services
- Neonatal and pediatric interfacility transport
- Neonatal and pediatric critical care—incapable
- Neonate and infant intensive care services—initial and continuing

The specifics of the code components that determine code selection are listed in the table and discussed in the next section. Before a level of service is decided upon, the correct type of service is identified.

A new patient is a patient who has not received any face-to-face professional services from the physician or other qualified health care provider within the past three years. An established patient is a patient who has received face-to-face professional services from the physician or other qualified health care provider within the past three years. In the case of group practices, if a physician or other qualified health care provider of the exact same specialty or subspecialty has seen the patient within three years, the patient is considered established.

If a physician or other qualified health care provider is on call or covering for another physician or other qualified health care provider, the patient’s encounter is classified as it would have been by the physician or other qualified health care provider who is not available. Thus, a locum tenens physician or other qualified health care provider who sees a patient on behalf of the patient’s attending physician or other qualified health care provider may not bill a new patient code unless the attending physician or other qualified health care provider has not seen the patient for any problem within three years.

Office or other outpatient services are E/M services provided in the physician or other qualified health care provider’s office, the outpatient area, or other ambulatory facility. Until the patient is admitted to a health care facility, he/she is considered to be an outpatient. Hospital observation services are E/M services provided to patients who are designated or admitted as “observation status” in a hospital.

Codes 99218-99220 are used to indicate initial observation care. These codes include the initiation of the observation status, supervision of patient care including writing orders, and the performance of periodic reassessments. These codes are used only by the provider “admitting” the patient for observation.

Codes 99234-99236 are used to indicate evaluation and management services to a patient who is admitted to and