Practical Tips

FAQs From the Coding and Reimbursement Hotline: Port Flush, 59 and 25 Modifiers, Anticoagulation, and Management

ASCO's Coding and Reimbursement Hotline receives calls that relate to a wide variety of issues and topics. Some recent questions that have been answered by the hotline are provided below.

Can we charge an office visit such as 99213 and also 96523 for the flush procedure?

No. Medicare will not pay separately for a port flush code (96523) when it is performed on the same day as any other physician fee schedule service. The port flush code, however, is separately payable if it is the only service billed that day. There are National Correct Coding Initiative edits in place that reinforce this policy. Therefore, you have the option to bill either the office visit or the port flush code with Medicare.

The Current Procedural Terminology (CPT) manual clearly states that the 96523 code should not be billed if an injection or infusion is provided on the same day. Therefore, private payers may have put in place specific coverage policies or billing edits similar to Medicare. It is best to verify the coverage policy for this service with your individual payers.

What is the rationale for appending the -59 modifier to the hydration services when reporting them with chemotherapy administration services?

Hydration services performed during chemotherapy are not separately payable under the Medicare program. The -59 modifier is used on the hydration administration codes to attest that the hydration was done either before or after the chemotherapy administration.

Private payers may have varying policies on hydration services performed with chemotherapy. As always, you should verify those policies with each individual payer.

When can we use 99212 through 99215 with a -25 modifier on days intravenous chemotherapy is given?

Medicare will pay for both a drug administration service and

a visit on the same day if a level 2 through 5 visit is performed. The visit code must be accompanied by modifier -25 to indicate that a separately identifiable evaluation and management service was furnished in addition to the drug administration.

The language found in the CPT manual specifically states that a different diagnosis is not required for evaluation and management services provided on the same day as drug administration services. As a reminder, the documentation should always support the level of service billed.

CPT includes codes for anticoagulation management. Does Medicare pay for these codes?

Two new codes for anticoagulation management (CPT codes 99363 and 99364) were published in the 2007 CPT manual. While private payers may recognize these codes, Medicare does not. The 2007 Medicare Physician Fee Schedule shows 99363 and 99364 as bundled services that are not separately billable.

Is there a way to know if my state has specific laws relating to the coverage of off-label indications used in cancer treatment?

Yes. One of the best resources to determine whether or not your state has laws relating to the coverage of off-label indications can be found on the National Cancer Institute's (NCI; Bethesda, Maryland) Web site. NCI follows state legislation, proposed and enacted, that addresses off-label indications used in cancer treatment. The organization has put together a chart containing the states and the relevant information on off-label coverage. The link to the chart is http://www.scdl-nci.net/Data/off-label_use_06_30_05.pdf.

Staff at ASCO are available to answer questions from oncologists and their practice staff. Give us a call at 703-299-1054 or e-mail us at practice@asco.org.

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