

Coding Tip of the Month: Archived

April 2024

A visit in the hospital setting that is "split" or "shared" by a physician or non-physician practitioner is subject to split/share billing guidelines. In 2024, CMS finalized their guidelines to split/shared billing to reflect changes enacted in the 2024 AMA CPT manual. In 2024, split/share service levels are determined by:

- Time: The practitioner spending the majority of time with the patient.
- Medical decision-making: The reporting provider performs the substantive portion of the medical decision-making, as defined by guideline instruction.
- Modifier -FS should be appended to the split/shared visit code.

[ASCO's Coverage and Reimbursement](#) resource on [Split/Share E/M Services](#) was updated to include more details on split/share billing, including updates, reporting criteria for time and medical decision making, and documentation requirements. Not all payers accept split/share billing. Please refer to individual payer policy for coverage.

March 2024

A new code covered in [ASCO's Care Management and SDOH G Comparison resource](#) is *G0136*, established by Medicare this year to capture the *administration of a Social Determinants of Health (SDOH) Risk Assessment tool*. *G0136* accounts for 5-15 minutes of administering the tool, and time may also contribute to other navigational services as indicated by Medicare.

Many practices may be utilizing a tool during navigational services, and this code now allows the assessment to be reported for reimbursement. It's important to note the risk assessment tool used **must be a standardized, evidence-based tool**.

February 2024

Effective January 1st, 2024, the visit complexity add-on code is effective for payment under the Medicare Physician Fee Schedule. According to a recent [ASCO in Action article](#), depending on the level of service reported a provider may see visit reimbursement increase from 7.3% to 69%.

G2211: Visit complexity add-on code for an office and/or outpatient evaluation and management service

The billing practitioner must provide ongoing medical care acting as a continuing focal point of all needed healthcare services AND/OR as part of care related to a single, serious or complex

condition, like cancer. See the visit complexity add-on code resource below for more information.

January 2024

According to a study cited in the [2020 ASCO Educational Book](#) on end-of-life conversations, only 26% of respondents living with cancer had discussed end-of-life care with their doctor. Facilitating discussions of goals of care, palliative care, and advance care planning into the oncology care plan is a key standard of Oncology Medical Home and the ASCO Certified program and support quality cancer care from diagnosis to end of life.

To report Advance Care Planning services, there are two associated codes:

99497: Advance care planning including explanation and discussion of advance directives by the physician or qualified health care professional, first 30 minutes

99498: Each additional 30 minutes

ASCO has multiple resources available to assist practices with the implementation and reporting of advance care planning services available throughout its website, not just on the Coding and Reimbursement page. We've included a full glimpse of all ASCO resources and articles on the topic in our Practice Administration Guide.

[Advance Care Planning practice administration guide](#)

[Coding Snapshot: Advance Care Planning](#)

[Practice Leadership Call – March 2022: Advance Care Planning](#)

[ASCO Educational Book – Bringing Death to Life: The Need for Honest, Compassionate, and Effective End-of-Life Conversations](#)

December 2023

In the [CMS 2024 Final Rule for the Physician Fee Schedule](#), several codes were created to report activities to address social determinants of health, care navigation, and visit complexity. ASCO has developed several new resources on these codes and services: [Care Management and SDOH G Code Comparison resource](#), which evaluates the similarities and differences between the Care Management CPT code family and the new Community Health Integration, Principal Illness Navigation, and SDOH Risk Assessment codes, and a one-page resource on the new [G2211 Visit Complexity Add-on Code](#).

November 2023

Codes to report procedures, supplies, and diagnoses are updated on a regular basis. HCPCS codes, which describe supplies such as drugs that are infused or injected, are updated quarterly by the Centers for Medicare and Medicaid Services. ICD-10-CM codes, other known as diagnosis codes, are updated annually effective October 1st. The American Medical Association (AMA) annually publishes the CPT code set in the AMA® CPT Professional Edition which goes into

effect January 1st each year. ASCO's resources covering the coding updates can be found on this page under "Coding and Reimbursement Updates".

October 2023

A significant, separate E/M service may be reported on the same day as chemotherapy using a modifier 25 if documentation and clinical circumstances support both the E/M service and chemotherapy are significantly separate procedures.

NCCI edits are in place for all evaluation and management services (99202-99215) when billed with any infusion and/or injection administration codes (CPT codes 96360-96542). Therefore, practices need to refer to the edits *for each code pair* (infusion/injection and evaluation and management codes) to determine if a modifier is allowed to bypass the NCCI edit in place. Links to resources on NCCI edits can be found on the ASCO Practice Central [Medicare Program](#) page.

Private payers may have their own policies regarding reporting of evaluation and management procedures on the same date as minor procedures.

September 2023

In last month's Tip of the Month, prolonged services for physicians and other qualified health care professionals on the date of service were discussed. However, there are other situations where prolonged services can be reported.

- When the prolonged services are provided by a physician/qualified healthcare professional on a date *other than the date of the encounter*:

If prolonged services without direct patient contact occur on a date other than the face-to-face evaluation and management service, codes 99358 and 99359 (*prolonged evaluation and management before/after direct patient care for the first hour and each additional 30 minutes*) can be used to report those prolonged services even if time wasn't used to select the level of the E/M. It must relate to a face-to-face E/M that either will or has occurred and related to ongoing patient management. Note these codes are not actively paid by CMS.

- When clinical staff time accounts for the prolonged services in office/outpatient setting:

Clinical staff face-to-face time accounting for prolonged services should be reported with 99415 and 99416 (*Prolonged clinical staff time during an evaluation and management service for first hour and each additional 30 minutes*). This requires direct supervision AND direct patient contact on the date of the encounter by the physician or other qualified health care professional. The staff time does not have to be continuous but only the face-to-face time should be counted. Time counted towards services other than evaluation and management service cannot be used towards prolonged services.

August 2023

When an evaluation and management level of service is based on time and the total time is over that of the maximum time indicated in the description of the service, prolonged service codes may be reported. AMA CPT guidelines allow prolonged services to be reported once the *maximum required* time of the primary service has been exceeded. CMS instructs 15 minutes beyond the *total* time of the primary service must be met to report any prolonged services.

Office and outpatient: 99417, G2212

Non-office and outpatient: 99418, G0316 (Hospital inpatient and observation), G0317 (Nursing facility), G0318 (Home or residence)

Refer to ASCO Practice Central's resources for more details and examples of prolonged services for **office** and **hospital services** for examples. The resources can be found on this page along with other resources on selecting codes based on time.

July 2023

New patients are defined under CPT guidelines as not having received any face-to-face services from the physician or other qualified health care professional of the same specialty and subspecialty who belongs to the same practice group within the past three years. Advanced practice providers and covering providers are considered the same specialty and subspecialty as the physicians they are working with.

Practice location does not affect this definition. If the provider changes practices and the provider OR another provider of the same specialty in the new group has provided any professional services to the patient within three years, the patient would be considered established.

Payers may have their own guidelines; therefore, it will be important to check their policies.

June 2023

When the patient is presenting for chemotherapy, immunotherapy, or radiation therapy, the primary diagnosis code should be an encounter code which reflects the therapy the patient is receiving at that encounter.

Example:

Z51.0 Encounter for antineoplastic radiation therapy

Z51.11 Encounter for antineoplastic chemotherapy

Z51.12 Encounter for antineoplastic immunotherapy

If the patient is presenting for a follow-up after the treatment has been completed, the provider would report the correct encounter for the follow-up diagnosis code as primary.

Example:

Z08 Encounter for follow-up examination after completed treatment for malignant neoplasm

In addition to the primary diagnoses above, the appropriate diagnosis codes related to the conditions requiring care would also be reported for the services provided.

May 2023

Specificity in diagnosis is crucial in the documentation and reporting of oncology diseases. One area of frequent confusion is the indication of primary versus metastatic cancer. For a primary cause of cancer caused by a neoplasm, the diagnosis would be reported with a code belonging to the range of C01-76 in Chapter 2 Neoplasms of the ICD-10-CM manual. If the cancer has spread to a secondary site, it should be documented and reported with a code found in the range of C77-79. Documentation should specify where both primary and secondary sites of neoplasm are located (unless they are unknown).

April 2023

A November 2022 [report](#) from the Office of the Inspector General showed that 67% of the Advance Care Planning services audited were not properly documented. For example, in some cases time spent on ACP services was not documented or did not distinguish from time spent on concurrent services. ASCO's [Advance Care Planning Practice Administration and Reimbursement Guide](#) can assist with ensuring your practice is knowledgeable about the documentation and reporting requirements of these services.

March 2023

Reporting guidelines instruct to code to the highest level of specificity. Having multiple bone marrow testing codes available, providers must select the code that most closely describes the procedure being performed. Take note that there are three codes describing a bone marrow biopsy and/or aspirate procedure:

- 38220 - bone marrow aspirate(s) alone
- 38221 - bone marrow biops(ies) alone
- 38222 – bone marrow biops(ies) and aspirate(s)

The above codes are not to be reported with one another if performed at the same site. These codes would **only** be reported together if performed at different sites and would require an appropriate modifier to indicate this. Bilateral procedures should not be reported with multiple units or lines and require an appropriate bilateral modifier, unless otherwise instructed by payer policy.

February 2023

As part of the 2023 OPPTS final rule, CMS is requiring all 340B entities to report a modifier on separately payable Part B drugs. The following modifiers should be reported with drugs acquired through the 340B program:

- Drug Wastage
 - JW: Report with discarded drug amount (not including overfill amounts)
 - JZ: Report for non-wasted amount of drug
- Provider Indicators
 - TB: Rural sole community hospitals, children’s hospitals, and PPS-exempt cancer hospitals
 - JG: All other 340B covered entities

The JW modifier is required for all providers beginning January 1, 2023, and the JZ modifier no later than July 1, 2023, in all outpatient settings. The provider indicator modifiers must be used no later than January 1, 2024. The information is mentioned in the ASCO Practice Central resource on [2023 Coding Updates](#). You can find additional information in [Chapter 17 of CMS’ Claims Processing Manual](#) as well as [CMS’ Hospital Outpatient Prospective Payment Final Rule](#).

January 2023

ASCO compiles all the latest coding updates for our members in one central location – ASCO Practice Central’s Coverage and Reimbursement page. ASCO provides updates as applicable as well as summaries of updates that come out on a quarterly and annual basis. For the most recent updates effective in January 2023, check out the [2023 Coding Update resource](#) combining CPT, ICD10-CM, and HCPCS updates, in addition to the [January 2023 Quarterly HCPCS update](#).

December 2022

CMS released the Physician Fee Schedule Final Rule in November. The rule serves as a federal document and provides guidance on coverage and reimbursement topics pertaining to healthcare services. An overview of the rule, including items relevant to oncology can be found on the November 17th recording of [ASCO’s Practice Leadership](#) calls and on the [ASCO in Action page](#).

Details regarding coding updates are available in [ASCO’s 2023 Coding Updates Guide](#), which includes both CPT and CMS information.

November 2022

Each quarter, CMS publishes updates to the HCPCS coding system. ASCO provides a summary of these updates with codes particularly pertinent to oncology. These can include the newest approved drug codes, revisions to pass-through status, and sometimes PLA (Propriety Laboratory Analysis) codes. The latest update is effective October 1st. ASCO’s summary for this HCPCS update and all other updates for 2022 are available on the [Coding and Reimbursement](#) page.

October 2022

The American Medical Association recently published the 2023 AMA CPT Professional Edition. Any updates in the CPT manual will go into effect on January 1st, 2023. Included in the 393 CPT changes are:

- Revisions to the Evaluation and Management Services guidelines and codes
- New sections for Digital Pathology Services and Artificial Intelligence
- New codes for Proprietary Laboratory Analyses (PLA) services and Genomic Sequencing Procedures
- Updates to radiology services
- Revisions to remote therapeutic monitoring services and codes

More details can be found in the [“2023 CPT Update”](#) resource on the Coding and Reimbursement page.

September 2022

For 2023, several categories of diagnoses relating to oncology have been updated in addition to codes created for better accuracy and specificity. The changes are connected to blood diseases, social determinants of health, long term drug codes for chemotherapy and immunotherapy, additions for patient non-compliance, and the creation of a category for caregiver non-compliance. Additionally, there are revisions to the unclassified codes for peripheral T-cell lymphoma and myelodysplastic disease. For more details and specifics on these changes, see the ASCO resource [“2023 ICD-10 Update”](#).

August 2022

Providers can now bill for total time spent on both face-to-face and non-face-to-face activities for office and outpatient evaluation and management services (with some exceptions). Be sure to document the time spent on the service and corresponding activities in the note to support the E/M service selected. For more information on selecting an E/M service based on time, see the ASCO resource [“2021 Evaluation and Management Changes: Selecting a Code Based on Time”](#).

July 2022

While chemotherapy patients do require some monitoring, not all chemotherapy plans fall under the classification as a drug requiring intensive monitoring. Drugs requiring intensive monitoring should have a high risk of morbidity. Monitoring can be done by lab test, physiologic test, or imaging but must be done for assessment of adverse effects, not for therapeutic efficacy.

June 2022

While a chemotherapy requiring intensive monitoring for toxicity may result in a high level of risk for comorbidity for the treatment management, the office visit may not result in a level 5 office visit. Office visits are based on the lowest level of two out of the three MDW sections when based on medical decision making.