CMS Manual System

Pub 100-19 Demonstrations

Transmittal 34

Department of Health & Human Services (DHHS)

Centers for Medicare & Medicaid Services (CMS)

Date: DECEMBER 16, 2005

Change Request 4219

SUBJECT: 2006 Oncology Demonstration Project

I. SUMMARY OF CHANGES: This one time notification provides information on the one-year oncology demonstration project for calendar year 2006. This project replaces the 2005 chemotherapy demonstration project. The oncology demonstration, applicable to services furnished in 2006, will build on the use of G-codes to gather more specific information about cancer patients, including their treatments; the spectrum of care they receive from their doctors; and whether or not the care represents best practice. Reporting will no longer be specific to chemotherapy administration services, but instead will be associated with physician evaluation and management (E & M) visits for established patients with cancer. The demonstration is available to office-based hematologists/oncologists who provide an E & M service of level 2, 3, 4, or 5 to an established patient (as reported under the American Association's Current Procedural Terminology), when the service is delivered to a patient with a primary diagnosis of cancer belonging to one of the following major diagnostic categories: cancer of the breast (invasive), colon cancer, rectal/recto-sigmoid cancer, prostate cancer, lung cancer (both non-small cell and small cell), gastric cancer, esophageal cancer , pancreatic cancer, ovarian cancer, head and neck cancer, non-Hodgkin’s lymphoma , chronic myelogenous leukemia, and multiple myeloma.

NEW/REVISED MATERIAL

EFFECTIVE DATE: January 1, 2006

IMPLEMENTATION DATE: January 17, 2006

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R = REVISED, N = NEW, D = DELETED – *Only One Per Row.*

R/N/D	Chapter / Section / SubSection / Title
N/A	

III. FUNDING:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2006 operating budgets.

IV. ATTACHMENTS:

One-Time Notification

**Unless otherwise specified, the effective date is the date of service.*

Attachment – One-Time Notification

Pub. 100-19	Transmittal: 34	Date: December 16, 2005	Change Request 4219

SUBJECT: 2006 Oncology Demonstration Project

I. GENERAL INFORMATION

A. Background:

In the physician fee schedule final rule published in the Federal Register on November 21, 2005, we announced the implementation of the oncology demonstration project for 2006. This project replaces the 2005 chemotherapy demonstration project.

We have adopted new G-codes for reporting under the 2006 demonstration in order to take a further step toward encouraging quality care and promoting best practices that should lead to improved patient outcomes. We will eliminate the calendar year 2005 G-codes (G9021 to G9032) specific to the assessment of patient symptoms. The revised HCPCS tape, sent to you on November 21, 2005, terminates codes, G9021 to G9032, effective December 31, 2005.

B. Policy

The oncology demonstration, applicable to services furnished in 2006, will build on the use of G-codes to gather more specific information about cancer patients, including their treatments; the spectrum of care they receive from their doctors; and whether or not the care represents best practice. The project will emphasize practice guidelines as the source for standard of care, permitting us to monitor and encourage quality care to cancer patients. Reporting will no longer be specific to chemotherapy administration services, but instead will be associated with physician evaluation and management (E & M) visits for established patients with cancer, visits that are frequent and essential to assuring quality of care and life for patients.

The demonstration is available to office-based hematologists/oncologists who provide an E & M service of level 2, 3, 4, or 5 (i.e. American Medical Association's Current Procedural Terminology (CPT) codes 99212, 99213, 99214 or 99215) to an established patient when the service is delivered to a patient with a primary diagnosis of cancer belonging to one of the following thirteen major diagnostic categories: cancer of the breast (invasive) (174.0-174.9), colon cancer (153.0-153.9), rectal/recto-sigmoid cancer (154.0, 154.1), prostate cancer (185), lung cancer (both non-small cell and small cell) (162.2 – 162.9), gastric cancer (151.0-151.9), esophageal cancer (150.0-150.9), pancreatic cancer (157.0, 157.1, 157.2, 157.3, 157.8, 157.9), ovarian cancer (183.0), head and neck cancer (140.0 –149.9, 161.0-160.9), non-Hodgkin's lymphoma (202.00-202.08, 202.80-202.98), chronic myelogenous leukemia (205.10, 205.11), and multiple myeloma (203.00, 203.01). The E & M services furnished by hematologists/oncologists for patients with other cancers as the principal diagnosis will not qualify under the demonstration.

The physician specialties that qualify under the 2006 oncology demonstration are: hematology (82), medical oncology (83) and hematology/oncology (90). Midlevel practitioners, such as nurse practitioners

or others who may bill independently for Medicare services, are not eligible to participate in this demonstration.

To qualify for the oncology demonstration payment, the physician must submit one G code from each of the following three categories for the same day an E & M of level 2, 3, 4, or 5 is provided: 1) the primary focus of the evaluation and management service; 2) the current disease state; and 3) whether current management adheres to clinical guidelines.

Payments should flow in tandem with patient-centered care, rather than chemotherapy administration. The 2006 demonstration meets this objective, linking data collection and payment to E&M rather than chemotherapy administration.

Practices reporting data on all three categories to Medicare will qualify for an additional oncology demonstration payment of $ 23.00 in addition to the E & M visit.

As with the 2005 demonstration, participation in this demonstration is voluntary and the practitioner self enrolls.

To facilitate the collection of this information, we have established 81 new G-codes to be reported by participants.

<u>G-codes for primary focus of E & M, current disease state, adherence to practice guidelines.</u>

G-codes for primary purpose of visit
G9050 to G9055 (6 codes)

G-codes for adherence to practice guidelines
G 9056 to G9062 (7 codes)

G-codes for current disease status
G9063 to G9130 (68 codes)

The new 2006 oncology G codes and their descriptors can be access on the CMS homepage at:
http://www.cms.hhs.gov/providers/pufdownload/anhcpcdl.asp

Establish the following allowances for the demonstration codes and determine payment based on the lesser of 80% of the actual charge or the allowance by code:

G 9050 to G9055 -------$7.67
G 9056 to G9062--------$7.67
G 9063 to G9130 -------$7.66

Although we have established separate allowances, either all three G codes are paid or no G code is paid. Never make payment when only one or two G codes are reported.

These amounts apply in all localities. These codes are paid on an assignment basis and the usual Part B coinsurance and deductible apply.

The demonstration project is applicable to services provided on or after January 1, 2006 and before January 1, 2007. The oncology demonstration applies only to Medicare beneficiaries who are not enrolled in a Medicare Advantage plan.

These codes have been added to the Medicare physician fee schedule database and are assigned the status indicator of "X".

The oncology demonstration is linked to the level 2, 3, 4 or 5 established patient office visit. The E & M visit may also be furnished on the day that chemotherapy is provided to the patient or it may be the only service the patient receives on that day from the oncologist. If the physician bills a medically necessary E & M in addition to the chemotherapy administration service, the physician should attach modifier 25 to the E & M service. This modifier is used to report a significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure, such as the chemotherapy administration service. The physician should appropriately document the patient's record to support the level of the E & M service billed.

The carriers should utilize the standard postpayment review activities to safeguard against inappropriate patterns of billing for the G codes.

The physician should document the medical record to support the selection of the oncology demonstration G codes. A separate Medlearn article on physician documentation and coding guidance for the oncology demonstration will be published after the release of this CR.

B. Policy:

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	**Requirements**	**Responsibility ("X" indicates the columns that apply)**								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4219.1	Contractors shall accept codes G9050 through G 9130 as valid codes for payment for calendar year (CY) 2006 dates of service.			X					X	

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4219.1.1	The type of service indicator for G9050 through G9130 is 1.			X					X	
4219.2	Contractors shall approve codes G9050 through G9130 if the requirements for payment (4192.2.1 through 2.7) are satisfied.			X						
4219.2.1	The provider reports three G codes on the same day of service and on the same claim; one code from each of the following categories: and submits charges for one code from each of the following code categories: 1. The primary focus of the evaluation and management service (i.e. G9050 to G9055); 2. Adherence to treatment guidelines (i.e. the G9056 to G9062); 3. The current disease status (i.e. the G9063 to G 9130 range).			X						
4219.2.2	The provider reports three codes as described in 4192.2.1 on the same date of service as an approved level 2, 3, 4, or 5 established office visit. These are CPT codes 99212, 99213, 99214 and 99215. NOTE: Providers need an E & M code and three codes from 4192.2.1. The E & M code does not have to be on the same claim as the three G codes from 4192.2.1			X						
4219.2.3	The date of service for the oncology demonstration codes and the related E & M service are after 12/31/2005 and before 1/1/2007.			X						

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4219.2.4	The diagnosis code reported and referenced is a primary diagnosis of cancer belonging to one of the following major diagnostic categories: cancer of the breast (invasive) (174.0-174.9), colon cancer (153.0-153.9), rectal/recto-sigmoid cancer (154.0, 154.1), prostate cancer (185), lung cancer (both non-small cell and small cell) (162.2 – 162.9), gastric cancer (151.0-151.9), esophageal cancer (150.0-150.9), pancreatic cancer (157.0, 157.1, 157.2, 157.3, 157.8, 157.9), ovarian cancer (183.0), head and neck cancer (140.0 –149.9, 161.0-160.9), non-Hodgkin's lymphoma (202.00-202.08, 202.80-202.98), chronic myelogenous leukemia (205.10, 205.11), and multiple myeloma (203.00, 203.01);			X						
4219.2.5	The place of service reported for codes G9050 to G9130 and the established visit code 99212, 99213, 99214, 99215 is office (11).			X						
4219.2.6	The claim for the oncology demonstration service is assigned.			X						
4219.2.7	The claim for the oncology demonstration is furnished by a physician specialty designated as hematology (82), medical oncology (83) or hematology/oncology (90).			X						
4219.3	If business requirement 4192.2.1 is not met (i.e. all the G codes are not reported on the same claim), contractors shall return/reject the G codes as unprocessable and use the following messages: **Claim Adjustment Reason Code**: 16 – Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice			X						

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		F I	R H H I	C a r r i e r	D M E R C	Shared System Maintainers				Other
						F I S S	M C S	V M S	C W F	
	remarks codes whenever appropriate. **Remittance Advice Remark Code**: MA 130 – Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information. **Medicare Summary Notice**: 9.2 – This item or service was denied because information required to make payment was missing. NOTE: If the E & M code is on the same claim, MCS contractors may elect to manually split claims and only return the unprocessable portion of the claim (e.g. process the evaluation and management code and reject the G codes) if the contractor believes it is cost effective to do so. However, no MCS systems changes for splitting claims are being mandated.									
4219.4	If more than one G code from the same category for the same date of service is billed on the same claim (e.g. the provider submits a claim for two or more G codes from a single category of justification for the visit), the carriers shall reject all G codes as unprocessable. Use the following messages: **Claim Adjustment Reason Code**: 125 – Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remark codes whenever appropriate. **Remittance Advice Remark Code**: MA130 – Your claim contains incomplete and/or invalid information, and no appeal rights are afforded			X						

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	because the claim is unprocessable. Please submit a new claim with the complete/correct Information. **Medicare Summary Notice**: 9.4 – This item or service was denied because information required to make payment was incorrect.									
4219.5	If a non-assigned claim is submitted by a nonparticipating provider for the G codes and related E & M service, contractors shall process for coverage and payment those services that do not require assignment (e.g. the evaluation and management service) and deny the G codes using the following messages: **Claim Adjustment Reason Code**: 111- Not covered unless the provider accepts assignment. **Remittance Advice Remark Code**: N149 – Rebill all applicable services on a single claim. **Medicare Summary Notice**: 16.6 – This item or service cannot be paid unless the provider accepts assignment.			X						
4219.5.1	Providers may resubmit oncology demo G codes that are denied for not accepting assignment and, in such instances, the G codes shall be approved if the related E & M codes were approved. If there is no approved E & M code for the same service date and POS as the G codes on the claim or in history, deny the G codes using the following messages: **Claim Adjustment Reason Code**: 107 – Claim/service denied because the related or qualifying claim/service was not previously paid or identified on the claim.			X						

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		F I	R H H I	C a r r i e r	D M E R C	Shared System Maintainers				Other
						F I S S	M C S	V M S	C W F	
	Medicare Summary Notice: 16.26 – Medicare does not pay for services or items related to a procedure that has not been approved or billed.									
4219.6	If a participating provider submits a nonassigned claim for the oncology demo G codes, process the claim as assigned and generate the following messages: **Remittance Advice Remark Code**: MA09 – Claim submitted as unassigned but processed as assigned. You agreed to accept assignment for all claims.			X						
4219.7	Oncology demo G codes that are billed for dates of service not within CY 2006 shall be returned/rejected as unprocessable using the following messages: **Claim Adjustment Reason Code**: B18 – Payment adjusted because this procedure code and modifier were invalid on the date of service. **Remittance Advice Remark Code**: N56 – Procedure code billed is not correct/valid for the services billed or the date or service billed. **Medicare Summary Notice**: 16.13 – The code(s) your provider used is/are not valid for the date of service billed.			X						
4219.8	Contractors shall deny oncology demo G codes that are not pointed to a cancer diagnosis covered under the oncology demonstration. The cancers included in the oncology demonstration are: cancer belonging to one of			X						

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	the following major diagnostic categories: cancer of the breast (invasive) (174.0-174.9), colon cancer (153.0-153.9), rectal/recto-sigmoid cancer (154.0, 154.1), prostate cancer (185), lung cancer (both non-small cell and small cell) (162.2 – 162.9), gastric cancer (151.0-151.9), esophageal cancer (150.0-150.9), pancreatic cancer (157.0, 157.1, 157.2, 157.3, 157.8, 157.9), ovarian cancer (183.0), head and neck cancer (140.0 –149.9, 161.0-160.9), non-Hodgkin's lymphoma (202.00-202.08, 202.80-202.98), chronic myelogenous leukemia (205.10, 205.11), and multiple myeloma (203.00, 203.01). Use the following messages: **Claim Adjustment Reason Code**: 11 – The diagnosis is inconsistent with the procedure. **Remittance Advice Remark Code**: M76 – Missing/incomplete/invalid diagnosis or condition. **Medicare Summary Notice**: 16.48 Medicare doe not pay for this item or service for this condition.									
4219.9	Contractors shall deny the oncology demo G codes if the place of service reported for the G codes (or related CPT code 99212, 99213, 99214, 99215) is other than "office" (POS code 11). Use the following messages to deny G codes not billed with POS 11: **Claim Adjustment Reason Code**: 58 – Payment adjusted because treatment was deemed by the payer to have been rendered in			X						

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		F I	R H H I	C a r r i e r	D M E R C	Shared System Maintainers				Other
						F I S S	M C S	V M S	C W F	
	an inappropriate or invalid place of service. **Remittance Advice Remark Code**: M77 – Missing/incomplete/invalid place or service. **Medicare Summary Notice**: 16.2 – This service cannot be paid when provided in this location/facility. Use the following messages to deny G codes when the related CPT code (99212, 99213, 99214, 99215) is other than POS 11: **Claim Adjustment Reason Code**: 107 – Claim/service denied because the related or qualifying claim/service was not previously paid or identified on this claim. **Remittance Advice Remark Code**: M16 – Please see our web site, mailings, or bulletins for more details concerning this policy/procedure/decision. **Medicare Summary Notice**: 21.21 - This service was denied because Medicare only covers this service under certain circumstances.									
4219.10	Contractors shall deny the oncology demo G codes if the physician specialty is other than 82, 83, or 90. Use the following messages to deny the G codes. **Claim Adjustment Reason Code: 185 –** The rendering provider is not eligible to perform the service billed. **Remittance Advice Remark Code**: N95 –			X						

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	This provider type/provider specialty may not bill this service. **Medicare Summary Notice**: 26.4 This service is not covered when performed by this provider.									
4219.11	Contractors shall load the following allowances for the G codes: G9050 to G9055 --------$7.67 G9056 to G9062---------$7.67 G9063 to G9130---------$7.66			X						
4219.12	Contractors shall determine approved charges for the oncology demo G codes based on the lower of the submitted charges or the CMS supplied allowances.			X						
4219.13	Contractors shall apply the usual Part B deductible and coinsurance to the oncology G codes.			X						
4219.14	Effective for claims with dates of service on or after January 1, 2006, CWF shall add the oncology G codes to bypass SNF consolidated billing for beneficiaries in a Part A stay.								X	

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4219.15	A provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic. Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.			X						

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions:

X-Ref Requirement #	Instructions
4219.1	Limiting charge provisions do not apply to the oncology demonstration G codes.

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: January 1, 2006 **Implementation Date:** January 17, 2006 **Pre-Implementation Contact(s):** Jim Menas for payment policy questions (410-786-4507); James.Menas@cms.hhs.gov and Kathleen Kersell for carriers claims processing issues (410-786-2033); Kathleen.Kersell@cms.hhs.gov **Post-Implementation Contact(s): Appropriate Regional Office Staff**	**Funding for implementation activities will be provided to contractors through the regular budget process.**

*__Unless otherwise specified, the effective date is the date of service.__