Part B Insider (Multispecialty) Coding Alert

ONCOLOGY: Chemotherapy Payments Trickling In? Here Are A Few Tricks To Help

5 successful tips put the claims-splitting nightmare to rest

Just as a house divided can't stand, if your codes have split into multiple claims, you could be facing delays or worse.

Many providers "have been paid minimally since the end of December," says **Roberta Bueller,** a San Francisco consultant who works with the **Community Oncology Alliance.** The COA has been tracking many provider complaints about the new chemo billing system. "It's crazy out there," she says.

Carrier reps and providers disagree as to whose claims-processing software is causing the glitch, with each blaming the other. In some states, carrier systems automatically split claims after the 13th line, providers claim, and this separates codes that don't make sense on separate claims.

But Part B carrier **HGS Administrators'** system can handle as many lines as a provider sends without breaking up the claim, insists Medical Director **Andrew Bloschichak.** Providers have leased or bought software systems that break up their claims after six or eight lines, and the claims are already split when HGSA receives them, Bloschichak says. With all the codes oncologists must bill, it's not unusual to see providers billing 12-18 codes for a single encounter, he notes.

The same thing could happen with other services besides oncology, Bloschichak points out. For example, an echocardiogram will have base and add-on codes, and similar consequences could result if these become split for some reason.

HGSA has been working with oncologists and the **Centers for Medicare and Medicaid Services** to find workarounds to reduce these problems, Bloschichak adds. One solution would be to recycle claims after a couple of days. That way, if the carrier held up a particular claim but not the other claims that went along with it, all of the claims could be reunited once the held-up claim had gone through. Bloschichak doesn't have a time frame for such a solution, but admits "the sooner the better."

Try One of These Winning Strategies

In the meantime, providers can't just sit around and wait for CMS and the carriers to solve the problem. Luckily, experts offer a few tips on avoiding the claims-split nightmare:

1. Try submitting the codes in a particular set order. Bueller recommends billing the initial chemotherapy code, followed by the three demonstration project codes, followed by drug administration and E/M codes, followed by the subsequent administration. "I don't know [if] that would work in 100 percent of the cases," but it would help, she advises.

2. Count the lines on the claim. If you know that your system splits claims after the sixth or eighth line, or the carrier splits claims after the 13th line, take that into account. Coder **Tracy Sweat** with **Piedmont Oncology Specialists** in Charlotte, NC, tells her charge entry personnel to count the first 13 lines on the claim. If the chemotherapy demonstration project codes start on the 12th or 13th line, she tells the charge entry person to start a new claim rather than break up those codes. The demonstration project codes have to be together, but they don't have to be on the same claim as the chemo administration codes, her carrier has told her.

3. If you're billing for a chemotherapy drug using an unlisted code such as J9999, then put that code on a separate claim by itself, urges Bloschichak. That way, when the carrier staff hold up the unlisted code to identify and

price it, the rest of the codes can go forward without any trouble.

4. HGSA published a guidance on its Web site on Feb. 9 to help providers deal with the claim splitting problem, Bloschichak says. The guidance encourages physicians to submit all their codes on a single claim wherever possible, or if they're billing on paper to submit multiple 1500 forms with the word "continued" in block 28 on all the forms except the last one, where block 28 should contain the total amount.

5. Don't use modifier -52 (Reduced services) for infusion codes, because the code for initial infusions is now defined as "up to one hour," HGSA notes on its Web site. So there's no need to use a modifier to denote infusions that last less than a full hour.