Outpatient Facility Coding Alert

Part D Coverage: Clear Your Confusion on Self Administered Drug by Focussing on Your Facility's Guidelines

Understand 5 factors related to how the drugs were used.

Coding for self-administered drugs is always a challenge, as the big question remains whether it shall be covered by Medicare Part B since self-administered drugs can get approved only in certain situations. These parameters make it very important to focus on how the drug was used when trying to code.

Start by Understanding What Medicare Covers

Medicare covers self-administered drugs given in the hospital inpatient setting and in certain circumstances, those provided on an outpatient basis, according to **Sarah Goodman, MBA, CHCAF, CPC-H, CCP, FCS**, president of the consulting firm SLG, Inc., in Raleigh, N.C. Medicare Part B (Medical Insurance) generally covers care given in a hospital outpatient setting, like an emergency department, observation unit, surgery center, or pain clinic.

Part B only covers certain drugs in these settings, like drugs given through an IV (intravenous infusion). Sometimes people with Medicare need "self-administered drugs" while in hospital outpatient settings. "Self-administered drugs" are those which the patients normally take on their own. Part B generally doesn't pay for self-administered drugs unless they are required for the hospital outpatient services that are covered by Medicare. However, if the patient is enrolled in a Medicare drug plan (Part D), these drugs may be covered.

According to reimbursement guidelines, Medicare will pay for drugs and biologicals under Part B for hospital outpatients if the drugs are:

- Self-administered, but covered by statute
- Incident to a physician's service and not usually self-administered
- Self-administered, but are so integral to a procedure or treatment it could not be performed without them
- Required in the performance of diagnostic services, even if self-administered.

Know What 'Integral' Means

In 2002, CMS provided some specific guidelines for understanding which selfadministered drugs are considered integral to the procedure. Transmittal A-02- 129 states, "Certain drugs are so integral to a treatment or procedure that the treatment or procedure could not be performed without them."

The transmittal cited the following examples of drugs that are integral to being able to perform the procedure:

- Mydriatic drops instilled into the eye to dilate the pupils, anti-inflammatory drops, antibiotic ointments, and ocular hypotensives that are administered to a patient immediately before, during, or immediately following an ophthalmic procedure
- Sedatives administered to patients in the operative prep area
- Barium or low-osmolar contrast media used for diagnostic imaging procedures
- Topical solutions for photodynamic therapy, local anesthetics, and antibiotic ointments.

Verify Your Facility's Definition of 'Integral'

To understand whether a drug is considered integral to a procedure depends on your facility's definition of integral. Therefore, it is important for you to know whether your facility defines integral for a particular patient or for every

patient. The challenge is that different payers have different guidelines, which are sometimes conflicting. As a result, integral can be defined in conflicting ways.

In Medicare's brochure "How Medicare Covers Self- Administered Drugs Given in Hospital Outpatient Setting," CMS tells beneficiaries, "Part B generally doesn't pay for self-administered drugs unless they are required for the hospital outpatient services you're getting." This language seems to indicate that self-administered drug coverage is patient-specific, not procedure-specific.

The drugs are categorized by your local MAC (Medicare administrative contractor), which determines whether or not to include consider a drug as self-administered. Check with your local MAC for further clarification if you commonly encounter situations similar to the examples provided.

Coders and billers should also review the Federal Register for further guidance on how to define integral. According to 67 FR 66767:

A drug would be treated as a packaged supply in cases where ... it is directly related and integral to a procedure or treatment and is required to be provided to a patient in order for a hospital to perform the procedure or treatment during a hospital outpatient encounter.

This guidance seems to indicate the individual patient's needs define integral, rather than the procedure.

"To handle the confusion, it is better to focus on the hospital guidelines as well as any guidance provided by your MAC," Goodman advises. "Many have published lists of non-covered self-administered drugs."

Also Be Versed With What Is Not 'Integral'

Although CMS does not specifically define what an integral part is, the Federal Register helps clarify some things.

According to 67 FR 66767 and Transmittal A-02- 129, drugs that are not directly related and integral or packaged supplies are:

- Drugs unrelated to the procedure or treatment. An example of this would be supplying a patient with aspirin for a headache while the patient receives chemotherapy treatment.
- Drugs given to a patient for his or her continued use at home. One example of this would be starting a patient on an oral antibiotic in the ED, then providing a prescription for continuing doses.
- Drugs the patient normally takes at home for example, a daily supply of insulin or hypertension medication for a patient undergoing outpatient surgery.

Based on this definition, integral relates to a particular patient. In the chemotherapy example, the patient needs aspirin for a headache and not because of the chemotherapy treatment.

Therefore, CMS appears to be looking at the individual patient, rather than the procedure.

This contrasts with how intermediaries determine whether a drug is self-administered. These payers take into account every patient rather than individual patients' circumstances. The MAC determines whether 50% of the beneficiary population can self-administer a given drug.

Make Your Patients Aware of the Differences

Every facility should prepare patient notices with clear explanations on self-administered drug policy so patients know that they may be responsible for any noncovered drugs.

Benefit: Making your own notice means you can tailor it to include specific information about the drug benefit issues rather than having it be very generic like an advance beneficiary notice (ABN). Your notice should also include the names of specific drugs the patient will have to pay for out-of-pocket.

Modifier GY: You should append modifier GY (Item or service statutorily excluded, does not meet the definition of any Medicare benefit...) when billing for non-covered drugs.

One of the most important reasons to include modifier GY is that it triggers an explanation of benefits to be sent to the beneficiary. This explains to them that they will be liable for the drugs. If coders leave modifier GY off the claim, this explanation of benefits will not be sent to the beneficiary.

"However, always remember to check with your MAC regarding self-administered drug and modifier reporting," Goodman says. Further guidance on a national level hopefully will be helpful in clarifying the guidelines. In the meantime, each hospital should review its own coverage policies and update them as necessary based on the available guidelines.