FACILITY CLINIC VISITS

There are two parts to every outpatient hospital encounter: the physician’s professional service, and the technical/facility clinic visit service that includes the work of the hospital’s ancillary staff and the hospital’s room and overhead costs, collectively called the hospital resources.

Hospitals report specific codes to Medicare for clinic visits, emergency department (ED) visits and critical care services. This manual will address certain clinic visits, as these encounters relate to infusion center services. CMS defines clinic visits as services provided to “a patient who presents to the hospital clinic for services, is registered and receives one or more of the clinical interventions.”

Since April 7, 2000 CMS has instructed hospitals to report facility resources for clinic visits using the CPT® Evaluation and Management (E/M) codes and to develop internal hospital guidelines for reporting the appropriate visit level. Because there was no national set of guidelines, CMS traditionally stated that internal guidelines should be designed to reasonably relate the documented intensity of hospital resources to the different levels of effort represented by the codes.

Effective January 1, 2014 CMS replaced the traditional five levels of visit codes for hospital technical clinic visits with a single new Level II HCPCS code representing a single level of payment for all clinic visits. In addition, this visit code will be reported for both new and established patients.

**G0463** Hospital outpatient clinic visit for assessment and management of a patient

According to the Medicare Claims Processing Manual, Chapter 2, Section 90.6:

The term “encounter” means a direct personal contact in the hospital between a patient and a physician, or other person who is authorized by State law and, if applicable, by hospital staff bylaws to order or furnish services for diagnosis or treatment of the patient...When a patient has follow-up visits with a physician in the hospital following an initial encounter, each subsequent visit to the physician will be treated as a separate encounter for billing.

The hospital is not billing for “nursing time” or “nursing services” as separately reportable services; these are not “nurse visits.” Instead, the hospital is charging for the technical component of the professional patient visit service.

Although the clinic visit codes report the technical component of a physician visit, in limited circumstances they may be reported for incident-to services perform by physician order in the outpatient department.

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Chemotherapy – Intra-Arterial Administration

Intra-arterial (IA) administration of chemotherapy is covered by Medicare contractors and certain other payors only for the treatment of patients with liver cancer and colon cancer that is metastatic to the liver.

Push technique describes a method of administering a medication directly into a vein or artery using a syringe and needle or butterfly needle. This usually takes less than 5 minutes, but can be longer and the volume of liquid administered is usually under 50 ml. An intravenous push is defined as either:

- An injection while the healthcare professional is continuously present during the administration, or
- An infusion of 15 minutes or less.

This means that if the nurse performs a drug administration service and is continuously present for 20 minutes to perform the injection, the service is considered to be a “push” coding purposes. In addition, if the nurse hangs a mini-bag and the infusion is completed in 15 minutes or less, this service is also reported with the code for a push.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>96420</td>
<td>Chemotherapy administration, intra-arterial; push technique</td>
</tr>
<tr>
<td>96422</td>
<td>infusion technique, up to 1 hour</td>
</tr>
<tr>
<td>+96423</td>
<td>infusion technique, each additional hour (List separately in addition to code for primary procedure)</td>
</tr>
</tbody>
</table>

- There are no “initial” or “each additional” push codes for intra-arterial chemotherapy.
- An intra-arterial push of chemotherapeutic agents occurs less frequently than an intravenous push.
- This code is most frequently reported by the medical oncologist who participates in chemoembolization of liver metastases.

Use code 96423 for infusion intervals greater than 30 minutes (that is, 31 minutes or more) beyond each 1-hour increment.
Fluids

Administration of intravenous fluid to maintain line patency (e.g., giving fluid between units of blood products or to flush an intravenous line between chemotherapy agents) is not infusion therapy and may be denied as not medically necessary. When the sole purpose of fluid administration (e.g., saline, D$_5$W) is to maintain patency of the access device, the infusion is neither diagnostic nor therapeutic; therefore, the infusion codes should not be assigned to represent this flushing procedure as hydration therapy. In addition, Medicare will not reimburse for saline used to administer the chemotherapy agents or to mix the agents (these substances are billed as supplies).

Separate Medicare payment is typically allowed for saline solution (J7030-J7070, J7120) when the diagnosis on the claim is dehydration, or the saline solution is required to accompany one of the chemotherapy agents billed on that date of service according to the label of the agent and physician order.

If less than 500 cc of D$_5$W or less than 250 cc of normal saline is provided to a patient, it is generally considered to be a supply and bundled or packaged into other services provided on the same day.

However, when the infusion of saline is administered sequentially (before or after chemotherapy or a therapeutic drug administration), the services may be reimbursed on the same day. Medical record documentation must support a physician order and medical necessity for the hydration service.

Documentation of the start and stop time for the chemotherapy or therapeutic drug administration is also necessary to ensure that the separate nature of the two infusions is correctly captured. If the infusion of saline or other hydration substance occurs at the same time as the chemotherapy or therapeutic infusion, it is considered to be the delivery method for the drugs and is not separately charged or reimbursed.
Biosimilar Biological Products

The Affordable Care Act (ACA) authorized an abbreviated pathway for the licensing of biosimilar biological products. Under this abbreviated pathway, a proposed biological product that is demonstrated to be biosimilar to a reference product can rely on certain existing scientific knowledge about the safety, purity and potency of the reference product to support licensure.

A biosimilar product has no clinically meaningful differences from a previously-approved reference product and only minor differences in clinically inactive components.

A reference biological product for a biosimilar biological product is defined as the biological product licensed under Section 351 of the Public Health Service Act (PHSA) that is referred to in the application of the biosimilar biological product.

CMS stated that because of the degree of similarity that biosimilars share with their reference products, it is appropriate to price biosimilar products in groups in a manner similar to how multiple source or generic drugs are currently priced. CMS has determined that the payment amount for a biosimilar biological product is based on the ASP (average sales price) of all NDCs (national drug codes) assigned to the biosimilar biological products included within the same billing and payment code.

The HCPCS codes and modifiers for biosimilar biological products will be established based on policy documented in the Medicare Physician Fee Schedule Final Rule.

For hospital charges billed under the Outpatient Prospective Payment System, CMS will award pass-through status to the first eligible biosimilar biological for each reference product. Subsequent biosimilars for that same reference product will not receive pass-through status.

The July 2016 Quarterly update for the Outpatient Prospective Payment System (OPPS) listed the following biosimilar products with their respective modifiers:

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Descriptor</th>
<th>SI</th>
<th>APC</th>
<th>Effective Date</th>
<th>Modifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q5101</td>
<td>Injection, filgrastim (G-CSF), biosimilar, 1 mcg</td>
<td>G</td>
<td>1822</td>
<td>03/06/2015</td>
<td>ZA – Novartis/Sandoz</td>
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<tr>
<td>Q5102</td>
<td>Injection, infliximab, biosimilar, 10 mg</td>
<td>K</td>
<td>1761</td>
<td>04/05/2016</td>
<td>ZB – Pfizer/Hospira</td>
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