Medicare
Hospital Manual

Department of Health and Human Services (DHHS)

HEALTH CARE FINANCING ADMINISTRATION (HCFA)

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CHANGE REQUEST 1115

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
Table of Contents	4-3 - 4-4 (2 pp.)	4-3 - 4-4 (2 pp.)
422.3 - 423.1	4-221 - 4-225 (5 pp.)	4-221 - 4-223 (3 pp.)

MANUALIZATION--*EFFECTIVE DATE*: Not applicable

Section 422.2, Oral Cancer Drugs, provides billing and payment instructions when reporting oral anti-cancer Prodrugs for services furnished on or after January 1, 1999. This information was previously released to you by your intermediary.

NEW/REVISED PROCEDURES--*EFFECTIVE DATE:* January 1, 2000
***IMPLEMENTATION DATE*: July 1, 2000**

Section 422.2, Oral Cancer Drugs, is revised to reflect the addition of three HCPCS codes, J8510, J8520, and J8521 for oral cancer drugs effective January 1, 2000. These HCPCS codes were included in the 2000 HCFA Common Procedure Coding System (HCPCS) Update that was released in October 1999. You must report a cancer diagnosis code when billing for these new HCPCS codes in FLs 67-75.

MANUALIZATION--EFFECTIVE DATE: Not applicable

Section 422.4, Oral Anti-Nausea Drugs as Full Therapeutic Replacements for Intravenous Dosage Forms as Part of a Cancer Chemotherapeutic Regimen, is a new section providing billing and payment instructions when reporting oral anti-nausea drugs used as full therapeutic replacements for intravenous dosage forms for services furnished on or after January 1, 1998. This information was previously released to you by your intermediary.

DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previous published in the manual and is only being reprinted.

Section

Billing for Medical and Other Health Services

DME

o Have the same active ingredients as a non-self-administrable anti-cancer chemotherapeutic drug or biological that is covered when furnished incident to a physician's service. The oral anti-cancer drug and the non-self-administrable drug must have the same chemical/generic name as indicated by the FDA's Approved Drug and Products (Orange Book), Physician's Desk Reference (PDR), or an authoritative drug compendium; or

-- Effective January 1, 1999 be a FDA-approved oral anti-cancer Prodrug, an oral drug ingested into the body that metabolizes into the same active ingredient that is found in the non-self-administrable form of the drug;

o Be used for the same indications (including off-label uses) as the non-self-administrable version of the drug; and

o Be reasonable and necessary for the individual patient.

Generic/Chemical Name	How Supplied	HCPCS	
Busulfan	2 mg/ORAL	J8510	
Capecitabine	150 mg/ORAL	J8520	
Capecitabine	500 mg/ORAL	J8521	
Cyclophosphamide	25 mg/ORAL	J8530	
	50 mg/ORAL	J8530	(Treat 50 mg. as 2 units)
Etoposide	50 mg/ORAL	J8560	
Methotrexate	2.5 mg/ORAL	J8610	
Melphalan	2 mg/ORAL	J8600	
Prescription Drug, Chemotherapeutic, NOS	ORAL	J8999	

Part B of Medicare pays 80 percent of the reasonable cost of oral cancer drugs furnished by a provider. Deductible and coinsurance apply. Bill for these drugs on the HCFA-1450 or its electronic equivalent. Enter revenue code 636 in FL 42 of the HCFA-1450, the name and HCPCS of the oral drug in FLs 43 and 44 on the HCFA-1450, and the number of tablets or capsules in FL 46 of the HCFA-1450. Each tablet or capsule is equal to one unit, except for 50 mg/ORAL of cyclophosphamide (J8530), which is shown as 2 units. Report oral anti-cancer Prodrugs under revenue code 636 in FL 42 and HCPCS code J8999 in FL 44. Complete the remaining items in accordance with regular billing instructions. A cancer diagnosis must be entered in FLs 67-75 of Form HCFA-1450 for coverage of an oral cancer drug or an oral cancer Prodrug.

422.3 Self-Administered Antiemetic Drugs.--Effective with dates of service on or after January 24, 1996, Medicare pays for self-administrable oral or rectal versions of self-administered antiemetic drugs when they are necessary for the administration and absorption of primary Medicare covered oral anti-cancer chemotherapeutic agents when a high likelihood of vomiting exists. The self-administered antiemetic drug is covered as a necessary means for the administration of the oral anti-cancer drug (similar to a syringe and needle necessary for injectable administration). Self-administered antiemetics which are prescribed for use to permit the patient to tolerate the primary anti-cancer drug in high doses for longer periods are not covered. In addition, self-administered

antiemetics used to reduce the side effects of nausea and vomiting brought on by the primary drug are not included beyond the administration necessary to achieve drug absorption. (See §230.4.)

Part B of Medicare pays 80 percent of the reasonable cost of self-administered antiemetic drugs furnished by a provider. Deductible and coinsurance apply. Bill for these drugs on Form HCFA-1450 or its electronic equivalent. Enter revenue code 636 in FL 42. For claims with dates of service on or after January 24, 1996 through March 31, 1996, enter HCPCS code J3490 in FL 44. For dates of service on or after April 1, 1996, enter one of the following HCPCS codes in FL 44, as appropriate:

K0415 Prescription anti-emetic drug, oral, per 1 mg, for use in conjunction with oral anti-cancer drug, not otherwise specified; or

K0416 Prescription anti-emetic drug, rectal, per 1 mg, for use in conjunction with oral anti-cancer drug, not otherwise specified.

Enter the name of the self-administered anti-emetic drug in FL 43 and the number of units in FL 46. Each milligram of the tablet, capsule, or rectal suppository is equal to one unit. Complete the remaining items in accordance with regular billing instructions.

Claims are edited to assure that the beneficiary is receiving the self-administered antiemetic drug in conjunction with a Medicare covered oral anti-cancer drug.

422.4 Oral Anti-Nausea Drugs as Full Therapeutic Replacements for Intravenous Dosage Forms As Part of a Cancer Chemotherapeutic Regimen.--Section 4557 of the Balanced Budget Act of 1997 provides coverage for claims with dates of service on or after January 1, 1998 for oral anti-emetic drugs as full therapeutic replacements for intravenous dosage forms as part of a chemotherapeutic regimen provided that the drug(s) be administered or prescribed by a physician for use immediately before, at, or within 48 hours after the time of administration of the chemotherapeutic agent.

For purposes of this provision, the allowable period of covered therapy is defined to include day one, the date of service of the chemotherapy drug (beginning with the time of treatment), plus a period not to exceed 2 additional calendar days, or a maximum period up to 48 hours. The oral anti-emetic drug(s) should only be prescribed on a per chemotherapy treatment basis. For example, only enough of the oral anti-emetic(s) for one 24 or 48-hour dosage regimen (depending upon the drug) should be prescribed/supplied for each incidence of chemotherapy treatment at a time. The beneficiary's medical record must be documented to reflect that the beneficiary is receiving the oral anti-emetic drug(s) as full therapeutic replacement for an intravenous anti-emetic drug as part of a cancer chemotherapeutic regimen. This will indicate that the Q codes listed in §422.4A are being reported when billing for the oral anti-emetic(s). The use of the appropriate Q code(s) on the claim will serve as affirmation of the correct use of the benefit. A cancer diagnosis must be entered in FLs 67-75 of Form HCFA-1450 for coverage of these drugs.

Payment for these drugs is made under Part B. Medicare pays 80 percent of the reasonable cost of these drugs furnished by a provider. Deductible and coinsurance apply.

Bill for these drugs on Form HCFA-1450 or its electronic equivalent.

A. Revenue Code and HCPCS Reporting.--Report the oral anti-emetic drug(s) under revenue code 636 in FL 42 "Revenue Code." For claims with dates of service on or after January 1, 1998 through March 31, 1998, report the HCPCS code J3490 in FL 44 "HCPCS/Rates." For dates of service on or after April 1, 1998 report the following HCPCS code(s), as appropriate, in FL 44:

Q0163 DIPHENHYDRAMINE HYDROCHLORIDE, 50 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at time of chemotherapy treatment not to exceed a 48 hour dosage regimen.

Q0164 PROCHLORPERAZINE MALEATE, 5 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen.

Q0165 PROCHLORPERAZINE MALEATE, 10 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen.

Q0166 GRANISETRON HYDROCHLORIDE, 1 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 24 hour dosage regimen.

Q0167 DRONABINOL, 2.5 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen.

Q0168 DRONABINOL, 5 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen.

Q0169 PROMETHAZINE HYDROCHLORIDE, 12.5 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen.

Q0170 PROMETHAZINE HYDROCHLORIDE, 25 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen.

Q0171 CHLORPROMAZINE HYDROCHLORIDE, 10 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen.

Q0172 CHLORPROMAZINE HYDROCHLORIDE, 25 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen.

Q0173 TRIMETHOBENZAMIDE HYDROCHLORIDE, 250 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen.

Q0174 THIETHYLPERAZINE MALEATE, 10 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen.

Q0175 PERPHENAZINE, 4 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen.

Q0176 PERPHENAZINE, 8 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hours dosage regimen.

Q0177 HYDROXYZINE PAMOATE, 25 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen.

Q0178 HYDROXYZINE PAMOATE, 50 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen.

Q0179 ONDANSETRON HYDROCHLORIDE, 8 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen.

Q0180 DOLASETRON MESYLATE, 100 mg, oral, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for an IV anti-emetic at the time of chemotherapy treatment, not to exceed a 24 hour dosage regimen.

Q0181 UNSPECIFIED ORAL DOSAGE FORM, FDA approved prescription anti-emetic, for use as a complete therapeutic substitute for a IV anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen.

NOTE: The 24 hour maximum drug supply limitation on dispensing, for HCPCS codes Q0166 and Q0180, has been established to bring the Medicare benefit as it applies to these two therapeutic entities in conformance with the "Indications and Usage" section of currently Food and Drug Administration approved product labeling for each affected drug product.

In addition, when billing for chemotherapy drugs (which includes oral cancer and IV chemotherapy drugs), you must report the HCPCS code of the chemotherapy drug in FL 44 under revenue code 636 in FL 42.

NOTE: When billing for an oral anti-emetic drug(s) on the hard copy UB-92 (Form HCFA-1450), report the name of the oral anti-emetic drug(s) in FL 43 "Description" on the appropriate revenue lines.

B. Line Item Dates of Service Reporting.--When billing for an oral anti-emetic drug(s) used as full replacement for intravenous forms, you are required to report line item dates of service for the oral anti-emetic(s). Line item dates of service are reported in FL 45 "Service Date" (MMDDYYYY). (See example below.)

C. Service Unit Reporting.--Report the number of units of the oral anti-emetic drug(s) in FL 46 "Service Units" for each drug reported. Each HCPCS code descriptor is equal to one service unit.

Complete the remaining items in accordance with regular billing instructions.

423. REQUIREMENT THAT BILLS BE SUBMITTED IN SEQUENCE FOR A CONTINUOUS INPATIENT STAY OR COURSE OF TREATMENT

When a patient remains an inpatient of a non-PPS hospital, distinct part unit, or swing-bed for over 30 days, you are permitted to submit a bill every 30 days. Hospice and home health claims must also be submitted in-sequence in order to permit accurate recording of hospice election periods and home health benefit periods. (See §402 for Frequency of Billing.) Bill your claims in sequence for each beneficiary you service. Your intermediary will install edits to prevent acceptance of a continuing stay claim or course of treatment claim until it has processed the prior bill. When the prior bill has not been processed, your intermediary will reject the bill back to you with the appropriate error message.

When an out-of-sequence claim for a continuous stay or course of treatment claim reaches your intermediary, it will search its history for the prior bill. Your intermediary will not suspend the out-of-sequence bill for manual review, but will search for an adjudicated claim. If the prior bill is not

in your intermediary's history, your intermediary will reject the incoming bill, requesting that the prior bill be submitted first, and the rejected bill only be submitted after you receive notice of adjudication of the prior bill. A typical error message follows:

> "Bills for a continuous stay or admission or for a hospice or home health course of treatment must be submitted in the same sequence in which services are furnished. If you have not already done so, please submit the prior bill. Then, resubmit this bill after you receive the remittance advice for the prior bill."

If you have already submitted the prior bill, please hold the rejected bill until you receive a remittance advice for the prior bill.

423.1 Need to Reprocess Inpatient or Hospice Claims In Sequence.--If you or any beneficiary or secondary insurer are disadvantaged by CWF's first-in/first-out (FI/FO) processing, notify your intermediary to arrange reprocessing of all affected claims. For hospice claims, your intermediary will notify you if a claim has been processed out-of-sequence.

Your intermediary will cancel any bills posted out-of-sequence and request that any other intermediary involved also cancel any affected bills. Your intermediary will reprocess all bills based on the actual sequence of the beneficiary's stays at the various providers. Your intermediary controls the sequence in which the bills are processed and posted to CWF. The CWF utilization record will be corrected to properly allocate full coinsurance and lifetime reserve days for inpatient stays and services for hospice election periods, as applicable.

The inpatient issue arises only when the beneficiary experiences multiple admissions (to the same or different facilities) during the spell-of-illness or the election period. This situation occurs most often when long-term care hospitals are involved.

This approach is used only for inpatient claims when the beneficiary, other insurer, or you have increased liability as a result of out-of-sequence processing. It is not used if the liability stays the same, e.g., if the deductible is applied on the second stay instead of the first, but there is no issue with regard to the effective date of supplementary coverage.