

EPO Questions and Answers

(From 12/12, 12/13, and 12/14/2006 EPO iLincs)

Note:

1. Effective April 1, 2007, providers no longer need to submit documentation with the initial claim when billing for anemia of chronic disease. The EJ modifier will no longer be required with subsequent claims. To bill for anemia of chronic disease, use ICD-9 code 285.29. The ICD-9 code for the cause of the anemia, must be placed in item 21, #1 (HI01 for electronic claims), then reference only #1 in item 24E on the CMS 1500 form (SV107 electronic record). Supporting documentation must be contained in the medical record and be available to Medicare upon request only. Answers to the following questions were prepared based on policy INJ-023 in effect on the dates of the EPO iLincs. Some information may no longer be current, due to the recent changes to the policy in 2007. (See March 2007 Communiqué)

2. Effective March 19, 2007, Medicare no longer covers EPO/DPA for anemia of cancer. (See April 2007 Communiqué)

3. Policy INJ-023 is being returned to the Carrier Advisory Committees in May, 2007. Watch our Website for the posting of the draft. Comments may be posted to the comment board.

General

1. When Wisconsin Physicians Service (WPS) Medicare conducted the Medical Reviews, what diagnosis did the provider use incorrectly most often?

Answer: Anemia of Chronic Disease was the diagnosis we found more often to be incorrect. The reviewer found that anemia due to chemotherapy was more appropriate.

2. How does a provider submit claims for a patient currently receiving EPO therapy transferring from another physician? We do not have the previous records.

Answer: Medicare can only allow EPO therapy when the situation meets the requirements. If the current provider cannot get the previous records, they would need to verify the patient meets the qualifications for EPO therapy. This can be done by repeating some labs and having the physician justify the continuation of the drug in question.

3. Does Medicare require a particular diagnosis in the first diagnosis code field?

Answer: Medicare will look at all diagnosis on the claim in determining payment. The only exception is when a non-covered routine diagnosis code links to a particular service. Medicare will deny the service as non-covered. See question #8.

4. Does a provider need to include the statement “documentation available upon request” on all claims for EPO therapy?

Answer: Please include the statement on all EPO therapy claims. WPS Medicare will evaluate documentation for claims with the diagnosis of anemia of chronic disease on a pre-pay basis. As with any other service with Medicare, we may request documentation on any service to justify our payment.

6. A specialist from a major medical center prescribed EPO therapy for the patient. The primary care physician provides the service to prevent the patient having to travel to the major medical center. Would WPS Medicare develop to my office or the major medical center for documentation?

Answer: WPS Medicare will request any needed documentation from the billing provider. Provider’s office should request needed documentation from the prescribing physician.

7. When billing for EPO services, all claims require a hematocrit with the submission. Is the requirement the hematocrit or can it be either the hematocrit or hemoglobin?

Answer: The Billing and Coding Guidelines for the INJ-023 indicate the claim can accept either the Hemoglobin or Hematocrit. The coding guidelines provide the applicable electronic loops.

8. I believe the correlation of diagnosis codes between 995.20 and 285.8 or 285.9 are incorrect. I believe the correct corresponding anemia code is 285.22.

Answer: Our Local Coverage Determination (LCD), INJ-023, indicates that when billing for chemotherapy induced anemia, the claim requires diagnosis code 995.20 along with 285.8 or 285.9. Claims without this coding combination will deny. If you disagree with this combination, you can go through our LCD reconsideration process. You can access instructions for this process at the following Web page address: http://www.wpsmedicare.com/policies/lmrp_recon.shtml

9. The policy requires certain lab values depending on the circumstances. How do we determine if the lab results are low, normal or high?

Answer: The laboratory and the physician determine the correct interpretation of any test results.

10. Does Medicare cover the Prophylactic use of EPO or DPA when started more than 30 prior to the elective hip or knee replacement procedure?

Answer: Medicare can provide coverage for three weeks of coverage when the patient’s condition and the documentation meet the policy requirements. You can access these in our Local Coverage Determination (LCD) INJ-023 at the following Webpage address: <http://www.wpsmedicare.com/policies/wisconsin/inj023.pdf>

11. Is a Bone Marrow Biopsy required for all EPO/DPA claims?

Answer: The results of a Bone Marrow Biopsy are only required in the use of EPO/DPA for the treatment of Myelodysplastic Syndrome but this information would be acceptable for other indications.

12. How often should providers repeat lab tests for Medicare purposes?

Answer: Medicare does not have any specific time parameters for repeating tests. However, providers should complete testing based on the provider's judgment to determine the effectiveness of the medication and the titration of the medication to obtain optimal results. (See the drug manufactures package insert)

13. Does Medicare require the providers to perform a bone marrow biopsy within a specific amount of time prior to the start of EPO/DPA therapy?

Answer: Medicare requires a bone marrow biopsy in patients with Myelodysplastic Syndrome. When providers use particular test results to determine an effective treatment for the patient's condition, the results must be recent enough to assist in determining the appropriate treatment for the patient. It would be up to the physician to determine if a bone marrow biopsy was needed in a given circumstance.

14. Can a provider fax in the documentation to support the use of EPO/DPA when submitting the claim electronically?

Answer: The provider should indicate in the narrative field "additional documentation available upon request." We will send a development letter asking for the documentation. The Medicare office is unable to receive and process a Fax at the same time as the claim submission.

15. Does Medicare require the date of the last Hemoglobin or Hematocrit with the submission of all claims?

Answer: Medicare does not require the date with the submission. However, providers should keep this information in the office files should Medicare request the information.

16. Our patient has CMML (Chronic Myelomonocytic Leukemia) can I bill with diagnosis codes 238.72, 238.73, 238.74, 238.75, 284.9 and 285.0?

Answer: Yes

17. Medicare has diagnosis codes 238.72, 238.73, 238.74 and 238.75 as payable codes for EPO/DPA administration. Should Medicare also allow EPO/DPA when the patient has diagnosis codes 238.71 and 238.76?

Answer: Medicare does not cover EPO/DPA when the patient's diagnosis is 238.71 or 238.76. The payment policy for EPO/DPA is INJ-023. This is a Local Coverage Determination (LCD). Wisconsin Physicians Service (WPS) Medicare has a

Redetermination process available for providers to request changes to a LCD. You can access the process at the following Webpage:

http://www.wpsmedicare.com/policies/lmrp_recon.shtml

18. If the patient is on oral or IV iron therapy, does this mean the administration of EPO/DPA is noncovered?

Answer: The patient needs adequate iron stores for EPO/DPA to work. If the patient is on iron therapy, he/she can still receive EPO/DPA. Refer to Policy INJ-023 for further information.

Anemia of chronic disease - Prior to April 1, 2007

1. When the patient has the diagnosis of anemia of chronic disease, can we submit multiple claims at the same time?

Answer: There are numerous requirements for a patient receiving EPO therapy for anemia of chronic disease. When starting a patient on EPO therapy, submit the initial claim indicating "documentation available upon request". WPS Medicare will request the initial documentation. Please hold all subsequent claims until the initial service processes. If WPS Medicare allows the initial claim, then submit the subsequent claims containing the EJ modifier. If WPS Medicare denies the initial claim, providers can and should request an appeal. The provider can submit the subsequent claims at this time to avoid any claims processing timeliness difficulties. If WPS Medicare denies the initial claim, the provider should notify the patient for any future services by using an Advanced Beneficiary Notification Form that Medicare would deny future claims. The patient then chooses whether to continue therapy.

2. Is the EJ modifier required for all subsequent claims for EPO/DPA?

Answer: A provider should only use the modifier when the diagnosis is anemia of chronic disease and only when WPS Medicare allows the initial claim.

3. The patient has diabetes and anemia. Is it appropriate to code the situation to anemia of chronic disease?

Answer: Medicare cannot provide coding assistance for provider claims. Providers are required to determine the correct diagnosis code and procedure code that accurately reflects the patient's condition and the services performed. Wisconsin Physicians Service published information in our January 2007 Communiqué that may help offices with these types of questions. The physician determines per the lab work-up if the person is likely to have anemia of chronic disease.

4. Should the claim contain the EJ modifier for all uses of EPO/DPA?

Answer: No, the provider submits the EJ modifier only on subsequent claims for EPO/DPA usage for Anemia of Chronic disease and only after Medicare approves the initial administration.

5. How do we document the claim when the patient started EPO/DPA therapy for anemia of chronic disease prior to their eligibility for Medicare?

Answer: Submit the first claim once the patient is eligible for Medicare without the EJ modifier. Include the statement “additional documentation available upon request” in the narrative portion of the electronic claim. When Medicare sends the request for documentation, submit the required information available before starting therapy and the current documentation. In addition, provide information surrounding the circumstances.

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REMINDER – Refer to Policy INJ-023 when billing for this service.