



# Billing Medicare for EPO

Presented by:  
Wisconsin Physicians Service - Medicare  
Provider Outreach & Education  
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# Disclaimer

This presentation is a tool to assist providers. The information is current as of the date listed. WPS Medicare has made every reasonable effort to ensure the accuracy of the information. However, the provider has the ultimate responsibility for correct submission of claims.

WPS Medicare bears no liability for the results or consequences of the misuse of this information. The Medicare Program provisions are contained in the relevant laws, regulations and rulings.

# What is EPO?

- Epoetin alfa (EPO)
  - Epogen
  - Procrit
- Darbepoetin alfa (DPA)
  - Aranesp®



# WPS Medicare EPO Policy

- Local Coverage Determination INJ-023  
Erythropoietin Stimulating Protein, Epoetin Alfa (EPO) , Darbepoetin Alfa (DPA)

<http://wpsmedicare.com/policies/wisconsin/inj023.pdf>

- Billing and Coding Guidelines/Companion Document

[http://wpsmedicare.com/policies/wisconsin/inj023\\_billing.pdf](http://wpsmedicare.com/policies/wisconsin/inj023_billing.pdf)

# Indications and Limitations of Coverage and/or Medical Necessity

- Patients with End Stage Renal Disease (ESRD)
- Coverage for EPO and DPA for other than ESRD
  - Anemia related to therapy with Zidovudine (AZT)
  - Chemotherapy induced anemia
  - Anemia Associated with non-myeloid malignancy
  - Anemia related to multiple myeloma
  - Patient diagnosis of Myelodysplastic Syndrome/Chronic myelomonocytic leukemia
  - Anemia of chronic disease
  - Prophylactic pre-operative use for reduction of allogenic blood transfusions prior to elective hip and knee surgery

# Patients with End Stage Renal Disease (ESRD)

- Patients in ESRD on dialysis
  - 285.21 is the only diagnosis (dx) code needed
- Patients with chronic renal failure not on dialysis
  - Requires chronic renal disease 585.1 - 585.9;  
**and**
  - Requires 285.8 or 285.9 to indicate the anemia
- Documentation must justify coverage, but need not be submitted with the claim

# Anemia Related to Zidovudine (AZT) Therapy

- Policy section provides criteria that differentiates patients that respond to therapy and those that do not respond to therapy
- Documentation must justify coverage, but need not be submitted with the claim
- The claim:
  - Requires 042 or 079.53 for AIDS treatment
  - Requires 285.8 or 285.9 for anemia

# Chemotherapy Induced Anemia

- Anemia must be due to the chemotherapy itself whether the chemotherapy is being used to treat cancer or another illness
  - Myeloid malignancies is an exception
- Policy section provides criteria for coverage
  - Requires 995.20 to indicate chemotherapy induced the anemia
  - Requires 285.8 or 285.9 to indicate the anemia
- Documentation must justify coverage, but need not be submitted with the claim

# Anemia associated with Non-Myeloid Malignancy

- Policy section contains required HCT and/or Hgb levels
- Claim submission
  - Requires 140.0-204.91, 230.0-238.6, 238.8-239.9, or 273.3 cancer dx
  - Requires 285.22 dx for the anemia
- Documentation must justify coverage, but the provider need not submit it with the claim
- Non-covered myeloid malignancies are listed in the policy (includes ICD-9 codes)

# Anemia related to Multiple Myeloma

- WPS Medicare will cover EPO or DPA to treat the anemia associated with this disease when the documentation in the patient's medical record supports the criteria in the policy
  - Requires 203.00 (multiple myeloma) dx
  - Requires 285.22 anemia dx
- Documentation must justify coverage, but the provider need not submit it with the claim

# Myelodysplastic Syndrome/Chronic Myelomonocytic Leukemia Criteria

- Myelodysplastic syndromes are characterized by abnormal and ineffective blood cell production and a variable risk to transformation to acute leukemia
- Chronic Myelomonocytic Leukemia (CMML) is vary rare
- The claim the following:
  - 238.72, 238.73, 238.74, 284.9 or 285.0 myelomonocytic leukemia dx
  - 285.8 or 285.9 anemia dx

# Myelodysplastic Syndrome/CMML Documentation (found in policy)

- Erythropoietin Level
- Bone Marrow Biopsy Report
- Start date of six week trial period
- Response to treatment at the end of trial period
- Lab results pertinent to treatment, such as ferritin, transferrin, Hgb or HCT
- Narrative evaluation regarding response to therapy
- Documentation must justify coverage, but need not be submitted with the claim

# Anemia of Chronic Disease

- The severity of this type of anemia is usually moderate and is rarely symptomatic or in need of EPO/DPA therapy
- Report diagnosis code 285.29 – the claim needs no other diagnosis code
- Six week trial period must verify patient responds to treatment

# Anemia of Chronic Disease

- Lab values substantiate the diagnosis of anemia of chronic disease
  - Low serum iron, low or normal iron binding capacity, normal or elevated serum ferritin and/or adequate iron stores in bone marrow
  - Pretreatment HCT level is 33 % or less; or patient has been transfusion dependent for at least 3 months
  - Pretreatment erythropoietin level is 100 MU/ml or less

# Amemia of Chronic Disease

- Initial dose claim always requires documentation
  - Provider must indicate “documentation available upon request” on initial claim
  - WPS Medicare will request the documentation
- Submit subsequent dose claim only if initial dose is approved by WPS Medicare
  - Append the EJ modifier

# Prophylactic Pre-operative Criteria

- EPO/DPA is covered for use in patients:
  - Who are undergoing hip or knee replacement;
  - Have an anemia with a Hgb between 10 and 14 mg/dl (this indication requires a lead time of at least 3 weeks prior to surgery);
  - Are not candidates for autologous blood transfusion;
  - Are expected to lose more than 2 units of blood; and
  - Have had a work-up so their anemia appears to be that of chronic disease

# Prophylactic Pre-operative Criteria

- A weekly dose regimen for 3 weeks prior to surgery (e.g., days 21, -14, -7) and on the day of surgery will be covered
- Requires:
  - V07.8 diagnosis for prophylactic pre-operative use prior to elective hip and knee replacement surgery
  - 285.8 or 282.9 to indicate the anemia
- Documentation need not be submitted with the claim

# Dosage of EPO and DPA (Section C of Policy)

- Based upon body weight and can vary among different diseases
- Dosage, frequency and duration of treatment should not exceed the accepted standards of practice for the covered condition
- Dosages are titrated to achieve a consistent Hgb/HCT level

# Physician Assessment Required

- Prior to therapy, a comprehensive assessment of the patient should include:
  - Hematocrit (HCT) or hemoglobin (Hgb)
  - Serum iron
  - Transferrin saturation; or serum ferritin and/or documentation of iron stores in bone marrow
  - Creatinine (for ESRD patients)
  - Bone Marrow Biopsy (for myelodysplastic disease)
  - Erythropoietin level (for myelodysplastic disease; AZT therapy, anemia of chronic disease)

# Documentation Requirements

- Medical record information should support the requirements of the policy. This includes laboratory reports and testing that supports the diagnosis and the required parameters/criteria listed in the policy.



**IMPORTANT!! ICD-9 CM codes  
must be coded to the highest level  
of specificity**

# Health Care Procedure Coding System (HCPCS) Codes for EPO/DPA

- For Patients with ESRD on Dialysis
  - J0886 Injection of epoetin alfa, per 1000 units
  - J0882 Injection darbepoetin alfa, per 1 mcg
- For Patients with Other than ESRD on Dialysis
  - J0885 Injection, epoetin alfa, per 1000 units
  - J0881 Injection, darbepoetin alfa, per 1 mcg

# Companion Article - Jurisdiction of Claims

- EPO services related to dialysis are not included in the Skilled Nursing Facility (SNF) Part A Prospective Payment System (PPS) rate
  - Excluded from SNF Consolidated Billing (CB)
- EPO services not related to dialysis are included in SNF CB

# Companion Article – Coding Guidelines

- A1 - If the initial dose of EPO or DPA was administered in another setting:
  - Subsequent office-administered EPO claims must include documentation that the initially administered EPO/DPA met coverage criteria as set forth in Policy INJ-023
- A2 – When billing for administration of EPO/DPA, use the applicable therapeutic injection codes only
  - 99211 is not acceptable if the only service is the injection
  - If a brief Evaluation & Management (E/M) service is provided
    - Bill 99211 with the drug code
    - Do not bill the therapeutic injection codes with 99211

## Companion Article – Coding Guidelines

- A3 – If an electronic submitter has additional information that Medicare may require, indicate “DOCUMENTATION AVAILABLE UPON REQUEST” IN THE NARRATIVE (NTE02) SEGMENT
  - The claim will be returned as unprocessable if this statement is missing or if the documentation is not returned on a timely basis
- A4 – Refer to the Companion Article for information that must be submitted with each claim

# Companion Article – Coding Guidelines for **EPO**

- B1 – Multiple doses of EPO may be included as a single line item
  - Enter the number of units administered in item 24G
  - The standard unit for EPO is 1000 units
  - When the dosage is not an even multiple of 1000 units, units must be rounded
    - Dosages 1 – 499 units, round down
    - Dosages 500 – 999 units, round up to the next 1000
  - Dates may be spanned for a maximum of 7 days per line item

# Companion Article – Coding Guidelines for EPO

- B2 – The patient's diagnosis is the determining factor in code submission
  - Use code J0886 per 1000 units for ESRD on dialysis
    - Indicate the HCT level in Item 19 on the claim form
  - Use code J0885 per 1000 units for indications for other than ESRD on dialysis
    - Indicate the latest Hgb or HCT level in Item 19 on the claim

# Companion Article – Coding Guidelines for DPA

- C - The patient's diagnosis is the determining factor in code submission
  - Use code J0882 per 1 mcg for ESRD on dialysis
    - Indicate the HCT level in Item 19 on the claim form or electronic equivalent
  - Use code J0881 per 1 mcg for indications for other than ESRD on dialysis
    - Indicate the latest HCT level in Item 19 on the claim form or electronic equivalent
  - DPA is available in microgram dosages
    - The standard unit for DPA is 1 mcg
    - Enter "1" for each 1 mcg administered

# Companion Article –Claims for Anemia of Chronic Disease (285.29) for EPO or DPA

- D - Initial claims must be submitted with documentation that includes:
  - Laboratory work up including Hgb and/or HCT, Red blood cell indices, erythropoietin level, serum iron, iron-binding capacity , serum ferritin and/or bone marrow iron stain results
- Progress notes that indicate the chronic disease associated with the anemia with a discussion as to the work-up of the anemia and a justification for EPO/DPA use

# Companion Article –Claims for Anemia of Chronic Disease (285.29) for EPO or DPA

- Do not submit a subsequent claim until the initial claim has been approved
  - Subsequent claims need to be submitted with the EJ modifier and do not require additional documentation, unless specifically requested

# Coding Resources

- American Medical Association (AMA)  
<http://www.ama-assn.org>
- CPT Information Services (CPTIS)  
1-800-634-6922
- General Health Care Procedure Coding System (HCPCS) Coding Questions  
[http://www.cms.hhs.gov/MedHCPCSGenInfo/20\\_HCPCS\\_Coding\\_Questions.asp](http://www.cms.hhs.gov/MedHCPCSGenInfo/20_HCPCS_Coding_Questions.asp)

# Questions?

Note: Should you find it necessary to forward a question related to the subject matter addressed in today's program, send your questions to:

[medicareadmin@wpsic.com](mailto:medicareadmin@wpsic.com)

Enter "EPO iLinc" in the subject line



Thank you for attending!

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return the teleconference survey