

Medlearn Matters Number: SE0588	Related Change Request (CR) #: N/A
Related CR Release Date: N/A	Effective Date: N/A
Related CR Transmittal #: N/A	Implementation Date: N/A

Documentation and Coding Guidelines for Medicare's 2006 Oncology Demonstration

Provider Types Affected

Hematologists and Oncologists participating in the 2006 demonstration.

Provider Action Needed

This *Medlearn Matters* Special Edition article should be viewed in conjunction with *Medlearn Matters* article SE0589, which relates to Change Request (CR) 4219. That CR, titled "2006 Oncology Demonstration," informs the Medicare carriers about the Medicare policy and claims processing procedures applicable to the 2006 Oncology Demonstration.

Medicare makes additional payments on claims submitted related to this demonstration when those claims contain the requisite information for making that additional payment, and the claims are submitted in conjunction with a qualifying visit. As noted in CR4219, a separate *Medlearn Matters* Special Edition article would be written to provide the oncology community with additional information on documentation and coding guidelines. This *Special Edition* article is for that specific purpose.

Background

Overview

The purpose of the 2006 oncology demonstration project is to capture the spectrum of services oncologists provide to Medicare beneficiaries with the listed cancers in SE0589 and CR 4219. Another purpose is to determine to what extent practice guidelines parallel care that hematologists/oncologists provide.

To those ends, the demonstration project is asking what the primary focus is of each evaluation and management (E & M) visit (to capture the spectrum), and with respect to that primary focus, whether or not the care follows practice guidelines.

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Participation

Participation in this project is voluntary and the physician participates by filing a claim for services (i.e. a level 2, 3, 4, or 5 established office visit with three separate G codes, one from each category) with the Medicare carrier. The demonstration only applies to E & M visits with patients who have a diagnosis in one of the 13 listed categories, and where the primary focus of the visit is management of that cancer, its complications, and the complications of its treatment. Eligible visits should include an ICD-9 code on the claim for one of the included cancers, and that cancer should be the first listed cancer diagnosis on the claim form. The cancer does not need to be the first listed diagnosis of any kind on the claim form.

Medicare does make additional payment on claims containing the necessary information requested in this demonstration. Three separate G codes, one from each category, must be supplied for each submission to qualify for that payment – i.e., one code for disease status, one for the primary focus of the visit, and one for guideline adherence.

Documentation

Physicians must identify the appropriate G-code for:

- 1) primary focus of visit;
- 2) current disease state;
- 3) adherence to guidelines

Physicians must also supply documentation in the patient chart in order to bill for the demonstration as described below. Local Medicare carriers have been advised that further documentation requirements are not to be imposed.

- 4) One alternative, that fully satisfies the documentation requirements, is to identify the source of the guideline (the American Society of Clinical Oncology, National Comprehensive Cancer Network, both, or “no guideline available”) consulted for reporting of guideline adherence and annotating the chart to reflect that source, using a phrase such as:
 - a. Demonstration project – ASCO;
 - b. Demonstration project – NCCN;
 - c. Demonstration project – ASCO & NCCN, or BOTH;
 - d. Demonstration project – No guideline available, or NONE or
 - e. Demonstration project – Clinical Trial, or CT

Reporting the title of the specific guideline that was consulted is not required. “Demonstration Project – Clinical Trial” should be used when the patient is on an IRB-approved clinical trial relevant to the service

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delivered during that visit.

Physicians do not have to provide additional documentation in the patient record beyond the elements listed above.

- 5) An alternative approach to documentation would be to use a template (e.g. "a flowsheet"), which would also fulfill all requirements under the demonstration. An example of such a template is included at the end of this article. The use of a documentation template such as the example provided fulfills all documentation requirements under the demonstration. If such a template is used, then physicians do not have to provide any additional documentation in the patient record. Local carriers are instructed to not impose additional documentation requirements.

Coding Guidance

Intent of the coding guidance

CMS is issuing this guidance to help ensure that reporting throughout the oncology community is consistent and data are meaningful. The guidance issued below is intended to clarify some of the distinctions between codes, and contextualize them within the general goals of the demonstration project.

Primary Focus of the Visit

The primary treating physician should determine the single code that best reflects the primary focus of that E & M visit on that particular day. It is assumed that many different issues are addressed in most E & M visits, and so physicians should make what to them seems the best choice. A narrative description of each code and a theoretical example follow.

G9050 Oncology Work-up Evaluation

This code should be used for visits where the patient is being evaluated or re-evaluated prior to or after a treatment course or contemplated treatment course. It is assumed that such visits occur usually when there is insufficient information about extent of disease or other characteristics of disease to support informed treatment decision making.

G9051 Oncology Treatment Decision/Treatment Management

This code should be used for all visits in which cancer directed therapy is being offered, described or discussed, therapy is being provided by the coding physician or by another physician (for instance, radiation therapy delivered at another facility), or the effect of therapy is being evaluated. This code should also be used for visits in which the patient's treatment course is altered (such as when doses are reduced), during treatment "holidays", and visits where the focus is

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management of toxicities or complications of treatment. Cancer directed therapy includes hormonal therapies and other therapies given for extended periods of time to prevent disease recurrence or relapse.

G9052 Oncology Surveillance for Disease

This code should be used for visits for patients who:

- Have completed definitive cancer-directed therapy (surgery, radiotherapy, chemotherapy, or combination);
- Have no definitive evidence of “active” disease at present;
- In whom further treatment (surgery, radiotherapy, chemotherapy) would likely be considered in the setting of disease recurrence;
- The primary focus of the visit is coordinating and explaining disease surveillance, or interpreting and explaining the results of that surveillance.

G9053 Oncology Expectant Management of Patient

This code should be used for visits for patients who:

- Have completed definitive cancer-directed therapy, or in which such treatment has been deferred (surgery, radiotherapy, chemotherapy, or combination);
- Have suggestive radiologic, clinical, or biochemical evidence of disease;
- Would likely be offered further active treatment (surgery, radiotherapy, chemotherapy) in the setting of disease progression (at primary or distant site);
- The primary focus of the visit is coordinating and explaining expectant management, or interpreting and explaining the results of that management.

G9054 Oncology Supervision Palliative

This code should be used for visits for patients who meet the following criteria:

- Cancer-directed therapy expected to prolong life is not being provided;
- It is not expected that such cancer directed therapy would be provided or offered in the future;
- The patient has active or suspected cancer that is expected to progress;
- The primary focus of the visit is managing, coordinating and explaining disease palliation.

Cancer directed therapy aimed at palliation of symptoms might be provided or coordinated in these visits e.g., palliative radiation therapy for bone metastases or chemotherapy for symptom alleviation.

G9055 Oncology Visit Unspecified

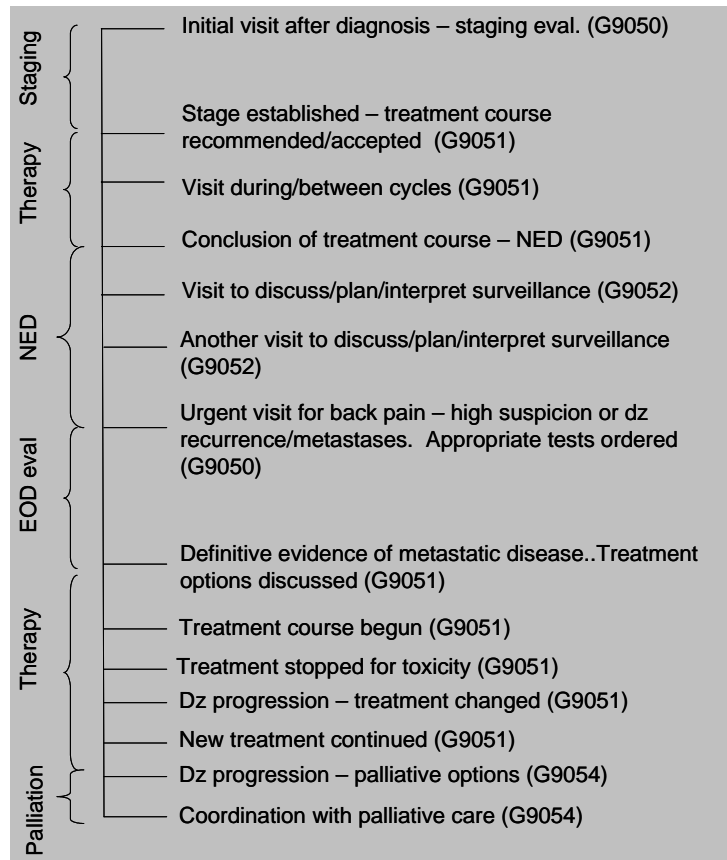
This code should be used for visits in which the primary focus is other than any of the listed options.

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A Theoretical Patient

**THEORETICAL
PATIENT**



Guideline Adherence

The treating physician should choose the single code that best reflects whether or not patient management adheres to practice guidelines, and if not, the best listed reason why not.

G9056 Oncology Practice Guidelines (Management adheres to guidelines)

Specifics about when to choose this code are discussed below in the section describing how guideline adherence should be evaluated with respect to the primary focus of the visit.

G9057 Oncology Practice Guidelines (Management differs from the guidelines as a result of enrollment in clinical trial)

This code is reserved for patients who are on an institutional review board approved clinical trial that dictates the care being provided in that visit. This will most often be relevant to visits in which the primary focus is on treatment, although some protocols may include experimental variation in evaluation,

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surveillance, expectant management, or palliation. If the primary focus of the visit (e.g. treatment) is the subject of the experiment, this code should be submitted. If the primary focus of the visit belongs to a category other than the one being evaluated in the clinical trial, then the treating physician should determine if that management adheres to guidelines.



Note: NCCN guidelines specify participation in a clinical trial as a recommended management strategy. For the purposes of this demonstration, if management differs from that specified in guidelines due to the patient's enrollment on an institutional review board approved clinical trial, G9057 should be reported as described above.

G9058 Oncology Practice Guidelines (Management differs from the guidelines because the physician disagrees with the guidelines)

This code is reserved for management that differs from guidelines because the treating physician disagrees with the recommendations included in the guideline.

G9059 Oncology Practice Guidelines (Management differs from the guidelines because the patient opts for different treatment)

This code is reserved for situations in which management differs from guidelines because the patient has chosen to receive alternative therapy or no therapy, despite the physician recommending management that parallels guidelines.

G9060 Oncology Practice Guidelines (Management differs from guidelines for reasons associated with patient illness)

This code is reserved for situations in which management differs from the guidelines because the patient's performance status, co-morbid illness, or other limitations preclude the management recommended in the guidelines.

G9061 Oncology Practice Guidelines (Patient's condition not addressed by guidelines)

This code is reserved for situations in which the recommended treatment or management for the patient's specific cancer and disease status is not addressed in the guidelines.

G9062 Oncology Practice Guidelines (Management differs from guidelines for other reasons)

This code is reserved for situations in which the management differs from the guidelines for a reason not listed above.

Disease Status

The physician providing the E&M service on that day should determine the single code that best represents the disease status of the patient's cancer. The disease status code should be relevant to the cancer that is the first listed cancer diagnosis on the claim form (not necessarily the first listed diagnosis).

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Note that, while there are 68 disease codes in total, for any given patient with an eligible diagnosis, a range of only 3 to 6 codes (depending on the specific diagnosis) needs to be considered.

Disease status should be based on the best available data at the time of the visit, unless otherwise specified. No additional diagnostic tests or evaluations should be performed for the purposes of further determining disease status for the purposes of this demonstration project.

Determining if Management is Adherent to Guidelines – Evaluating Guidelines based on the Primary Focus of Visit

The primary focus of the visit as documented should link to the guidelines that are to be evaluated. If the primary focus of the visit is work-up/evaluation, for instance, then the guidelines that should be referenced are those that describe the recommendations for work-up/evaluation. What follows is a simple table and accompanying list of items to consider in the guidelines when coding for guideline adherence for a particularly focus of a visit, followed by a narrative description.

Focus of the visit	What to look for
G9050 Oncology work-up evaluation	Compare tests obtained to those recommended in guidelines
G9051 Oncology treatment decision/treatment management	Compare chemotherapy, hormonal therapy, immunotherapy, and radiotherapy treatments offered or provided to those recommended in guidelines
G9052 Oncology surveillance for disease	Compare surveillance approach, such as tests and frequency of tests, to that recommended in guidelines
G9053 Oncology expectant management of patient	Compare expectant management approach, such as tests and frequency of tests, to that recommended in guidelines
G9054 Oncology supervision of palliative therapies	Compare management of patient's primary symptom, complaint, or complication in that visit to that recommended in guidelines
G9055 Oncology visit unspecified	Compare relevant management to relevant guidelines

G9050 Oncology work-up evaluation

When coding for guideline adherence, compare the tests listed in the guidelines for initial diagnosis or evaluation of recurrence to what is being ordered for the patient. If largely similar, with most or all recommended tests ordered/obtained and few or no tests ordered/obtained that are not recommended, code that management adheres to practice guidelines

G9051 Oncology treatment decision/treatment management

When coding for guideline adherence, compare the active cancer directed treatments (specifically chemotherapy, hormonal therapy, immunotherapy and/or radiotherapy) that are being discussed, considered, offered, or provided to those recommended in the guidelines. If treatment(s) that are recommended are being

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offered or provided, and treatment(s) that are not recommended are not being offered or provided, then code that management adheres to practice guidelines.

- a) Chemotherapy, hormonal therapy, and immunotherapy treatments that are offered or being provided should be considered to parallel guidelines if they are being provided as part of a recommended combination, at the doses and for the number of cycles or duration that is recommended (or at reduced doses or number of cycles for patient specific reasons), and as the "line" of therapy that is recommended.
- b) Radiotherapy should be coded as adherent to guidelines if the patient has been recommended to receive radiotherapy, been referred for radiotherapy, or is receiving/has received radiotherapy.
- b) If multi-modality therapy is recommended, treatment should be coded as adherent to guidelines if all modalities are offered or provided, meeting the criteria listed in *a* and *b* above.

Please note: Surgical therapy is not a focus of this demonstration project, so the treating physician is not expected to assess the appropriateness of surgical care in the context of guidelines for the purpose of identifying the appropriate G code.

G9052 Oncology surveillance for disease

When coding for guideline adherence, compare the tests and frequencies listed in the guidelines for disease surveillance with the tests and frequencies recommended in the guidelines. If largely similar, with most or all recommended tests ordered/obtained at approximately the recommended intervals, and few or no tests ordered/obtained that are not recommended, code that management adheres to practice guidelines

G9053 Oncology expectant management of patient

When coding for guideline adherence, compare the tests and frequencies listed in the guidelines for expectant management with the tests and frequencies recommended in the guidelines. If largely similar, with most or all recommended tests ordered/obtained at approximately the recommended intervals, and few or no tests ordered/obtained that are not recommended, code that management adheres to practice guidelines.

G9054 Oncology supervision of palliative therapies

When coding for guideline adherence in association with this code, the relevant guidelines on supportive care and palliation should be consulted. High quality palliative care is by its nature multi-dimensional in nature, making its delivery challenging, and making coding for guideline adherence burdensome. To simplify participation in the demonstration project, the coding physician should report whether the patient's primary symptom, complaint, or complication that is being managed in that visit is being managed according to practice guidelines, as judged by the treating physician.

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G9055 Oncology visit unspecified

When coding for guideline adherence in association with this code, the guidelines covering the relevant service should be consulted, or if no guidelines exist, that should be reported.

Additional Information

For additional information, please see *Medlearn Matters* article SE0589, which can be viewed at

<http://www.cms.hhs.gov/MedlearnMattersArticles/downloads/SE0589.pdf> on the CMS website.

Example of a Documentation Flowsheet

On the following page, there is an example of a flowsheet that could be included in the chart of a patient with breast cancer. Hypothetical data have been entered for one visit, occurring on January 1st, 2006.

To use this flowsheet, the treating physician, for a visit on a particular day, checks one code from each of first two areas, and annotates the flowsheet to designate the guideline that was consulted for that visit next to the relevant code in the guideline adherence category.

Completed in this manner, this flowsheet would satisfy all documentation requirements.

The source of the guideline can be annotated as follows: American Society of Clinical Oncology (ASCO), National Comprehensive Cancer Network (NCCN), both guidelines consulted (BOTH), no guideline available (NONE), patient on Clinical Trial (CT).

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Date					Primary Focus of Visit	
1/1/06					G9050	Work-up, evaluation, or staging at the time of cancer diagnosis or recurrence
	X				G9051	Treatment decision-making after disease is staged or restaged, Discussion of treatment options, supervising/coordinating active cancer directed therapy or managing consequences of cancer directed therapy
					G9052	Surveillance for disease recurrence for patient who has completed definitive cancer-directed therapy and currently lacks evidence of recurrent disease; cancer directed therapy might be considered in the future
					G9053	Expectant management of patient with evidence of cancer for whom no cancer directed therapy is being administered or arranged at present; cancer directed therapy might be considered in the future
					G9054	Supervising, coordinating or managing care of patient with terminal cancer or for whom other medical illness prevents further cancer treatment; includes symptom management, end-of-life care planning, management of palliative therapies
					G9055	Other, unspecified service not otherwise listed
					Disease State	
					G9071	Invasive female breast cancer (does not include ductal carcinoma in situ); adenocarcinoma as predominant cell type; Stage I or Stage IIA-IIB; or T3, N1, M0; and ER and/or PR positive; with no evidence of disease progression, recurrence, or metastases
	X				G9072	Invasive female breast cancer (does not include ductal carcinoma in situ); adenocarcinoma as predominant cell type; Stage I or Stage IIA-IIB; or T3, N1, M0; and ER and PR negative; with no evidence of disease progression, recurrence, or metastases
					G9073	Invasive female breast cancer (does not include ductal carcinoma in situ); adenocarcinoma as predominant cell type; Stage IIIA-IIIIB; and not T3, N1, M0; and ER and/or PR positive; with no evidence of disease progression, recurrence, or metastases
					G9074	Invasive female breast cancer (does not include ductal carcinoma in situ); adenocarcinoma as predominant cell type; Stage IIIA-IIIIB; and not T3, N1, M0; and ER and PR negative; with no evidence of disease progression, recurrence, or metastases
					G9075	Invasive female breast cancer (does not include ductal carcinoma in situ); adenocarcinoma as predominant cell type; M1 at diagnosis, metastatic, locally recurrent, or progressive
					G9076	Invasive female breast cancer (does not include ductal carcinoma in situ); adenocarcinoma as predominant cell type; extent of disease unknown, under evaluation, pre-surgical or not listed
					Practice Guideline Use	
	ASCO				G9056	Management adheres to guidelines
					G9057	Management differs from guidelines as a result of patient enrollment in an institutional review board approved clinical trial
					G9058	Management differs from guidelines because the treating physician disagrees with guideline recommendations
					G9059	Management differs from guidelines because the patient, after being offered treatment consistent with guidelines, has opted for alternative treatment or management, including no treatment
					G9060	Management differs from guidelines for reason(s) associated with patient comorbid illness or performance status not factored into guidelines
					G9061	Patient's condition not addressed by available guidelines
					G9062	Management differs from guidelines for other reason(s) not listed

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