



Pre-launch Coding, Analysis, and Strategy.

How Xcenda's coding recommendations helped a manufacturer minimize barriers at launch.

The Need

A large biotech manufacturer was developing a completely new physician-administered monoclonal antibody expected to have multiple indications and to be used in various sites of care. To understand how payers would reimburse physicians and hospitals for the drug, the client wanted to know if there were existing codes that adequately described the product and the conditions associated with it, as well as understand how the

codes would be used. Payment in these settings is often tied to a particular code.

Without appropriate coding, claims processing may be delayed, inappropriate payments may occur, and product utilization may be impacted. Understanding codes to report new drugs, procedures, and diagnoses was essential for strategic development of the drug.

The Xcenda Solution

Using our team of certified professional coders, Xcenda conducted a coding analysis to determine the most complete and accurate set of product, procedure, and diagnosis codes. The objective of this assessment was to determine the most appropriate coding options for healthcare providers to use. Our coding assessment included an overview of current coding systems, such as ICD-9-CM diagnosis and procedure codes, HCPCS codes, and CPT codes. The assessment encompassed:

- Coding and billing requirements
- Application requirements for requesting a new HCPCS, CPT, and ICD-9-CM code
- Recommendations for the likelihood of securing a new HCPCS, CPT, and ICD-9-CM code, including an assessment of the risks and opportunities in using existing codes

In addition to our coding analysis, Xcenda contacted representatives from relevant professional societies who serve as advisors to the CPT Editorial Panel. Xcenda interviewed these advisors to gain feedback on their recommendations and support for a new a CPT code.

Coding Expertise at Work

Xcenda submitted a request to the AMA's CPT Information Services to verify the appropriate procedure codes. The AMA evaluated what was involved in the procedure and provided advice on how to code for it. Xcenda created a HCPCS code application and submitted it to the client for review. Once approved, the client submitted the package to the HCPCS Workgroup at the Centers for Medicare and Medicaid Services (CMS) for its review in advance of the deadline.

The Outcome

The analysis revealed that:

- Existing ICD-9-CM codes were sufficient to report the diagnoses associated with the drug.

“The team’s responsiveness was most refreshing and made all the difference in this project.”

– Senior Director, Access & Reimbursement,
Large Biotech

- Existing CPT codes were adequate to report the administration service.
- There was not a unique HCPCS or pass-through code to report the drug, so miscellaneous or unlisted codes would be used at product launch until unique codes were assigned.
- Miscellaneous codes require the provider to submit additional documentation with the claim, which can be confusing. Payers must manually process claims with miscellaneous codes, which frequently results in inappropriate, delayed, or unprocessed claims. Payment delays, especially for expensive drugs, affect a provider's ability to pay the distributor.

Xcenda recommended submitting a coding application to CMS for a HCPCS and pass-through code. The FDA approved the drug, and CMS approved the pass-through application and the pass-through code within 6 months. The HCPCS application was submitted shortly thereafter. CMS approved the application, and the J-code became effective.

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