Oral Antiemetic Drugs (Replacement for Intravenous Antiemetics)

Tricenturion

Contractor Information	
Contractor Name	Tricenturion
Contractor Number	77011
Contractor Type	DMERC
LMRP Information	
A "Local Coverage Determination" (LCD), as established by Section 522 of the Benefits Improvement and Protection Act, is a decision by a fiscal intermediary or carrier whether to cover a particular service on an intermediary-wide or carrier-wide basis in accordance with Section 1862(a)(1)(A) of the Social Security Act (i.e., a determination as to whether the service is reasonable and necessary). The difference between LMRPs and LCDs is that LCDs consist only of "reasonable and necessary" information, while LMRPs may also contain category or statutory provisions. The final rule establishing LCDs was published November 11, 2003. Effective December 7, 2003, CMS's contractors will begin issuing LCDs instead of LMRPs. Over the next 2 years (until December 31, 2005) contractors will convert all existing LMRPs into LCDs and articles. Until the conversion is complete, for purposes of a 522 challenge, the term LCD will refer to both 1.) Reasonable and necessary provisions of an LMRP and, 2.) an LCD that contains only reasonable and necessary language. Any non-reasonable and necessary language a contractor wishes to communicate to providers must be done through an article.	
LMRP Database ID Number	L5058
LMRP Version Number	10
LMRP Title	Oral Antiemetic Drugs (Replacement for Intravenous Antiemetics)
Contractor's Policy Number	OEMT20030701
AMA CPT Copyright Statement	CPT codes, descriptions and other data only are copyright 2004 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS Clauses Apply. CDT-4 codes and descriptions are © 2004 American Dental Association. All rights reserved.
CMS National Coverage Policy	None
Primary Geographic Jurisdiction	CT DE MA ME NH NJ NY PA RI VT
Oversight Region	Region III
CMS Consortium	Northeast
DMERC Region LMRP Covers	Region A

Original Policy Effective Date	For services performed on or after 01/01/1999
Original Policy Ending Date	
Revision Effective Date	For services performed on or after 07/01/2003
Revision Ending Date	
LMRP Description	Oral Antiemetic Drugs (Replacement for Intravenous Antiemetics)
Indications and Limitations of Coverage and/or Medical Necessity	**COVERAGE AND PAYMENT RULES:** For any item to be covered by Medicare, it must: 1) be eligible for a defined Medicare benefit category, 2) be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, and 3) meet all other applicable Medicare statutory and regulatory requirements. For the items addressed in this regional medical review policy, the criteria for "reasonable and necessary" is defined by the following indications and limitations of coverage and/or medical necessity. For an item to be covered by Medicare, a written signed and dated order must be received by the supplier before a claim is submitted to the DMERC. If the supplier bills for an item addressed in this policy without first receiving the completed order, the item will be denied as noncovered. An oral antiemetic drug billed with codes Q0163-Q0181 is covered if all of the following criteria (1-4) are met: 1. The drug has been approved by the Food and Drug Administration (FDA) for use as an antiemetic, and 2. The drug has been ordered by the treating physician as part of a cancer chemotherapy regimen, and 3. The drug is used as a full therapeutic replacement for an intravenous antiemetic drug that would otherwise have been administered at the time of the chemotherapy treatment, and 4. The initial dose of the oral antiemetic drug is administered within 2 hours of the administration of the chemotherapy drug. If criteria 1, 2, 3, or 4 are not met, oral antiemetic drugs billed using codes Q0163-Q0181 will be denied as noncovered. Criterion 3 is not met when the chemotherapy drug is an oral drug or when the chemotherapy drug is administered intravenously in the home setting because the type and dosage of chemotherapy drugs administered in these situations do not require intravenous antiemetic drugs. If all of the above criteria (1-4) are met, the quantity of oral antiemetic drugs covered for each episode of chemotherapy cannot exceed the initial loading dose plus 48 hours of therapy. However, for the drugs granisetron (Q0166) and dolasetron (Q0180), the quantity of drugs covered for each episode of chemotherapy is limited to the initial loading dose plus 24 hours of therapy. Quantities of drugs in excess of these amounts are noncovered. More than one oral antiemetic drug may be covered for concurrent use if more than one oral drug is needed to fully replace the intravenous drugs that would otherwise have been given.

	The supplier may dispense only a single course of oral antiemetic drugs at one time. Drugs may be covered only if dispensed and billed to Medicare by the entity that actually dispenses the drug to the Medicare beneficiary, and that entity must be permitted under all applicable federal, state, and local laws and regulations to dispense drugs. Only entities licensed in the state where they are physically located may bill the DMERC for oral antiemetic drugs. Physicians may bill the DMERC for drugs if all of the following conditions are met: the physician is 1) enrolled as a DMEPOS supplier with the National Supplier Clearinghouse, and 2) dispensing the drug(s) to the Medicare beneficiary, and 3) authorized by the State to dispense drugs as part of the physician's license. Claims submitted by entities not licensed to dispense drugs will be denied for lack of medical necessity. Refer to the Oral Anticancer Drugs policy for information on coverage of antiemetic drugs used in conjunction with oral anticancer drugs.
CPT/HCPCS Section	This Section Contains National Codes Assigned by CMS on a Temporary Basis
Benefit Category	Oral Antiemetic Drugs
Coverage Topic	Chiropractic Services Clinical Trials (Inpatient) Clinical Trials (Outpatient) Chemotherapy (Inpatient) Chemotherapy (Outpatient) Cardiac Rehabilitation Programs
Coding Information	
CPT/HCPCS Codes	The appearance of a code in this section does not necessarily indicate coverage. HCPCS MODIFIERS: EY - No physician or other licensed health care provider order for this item or service

Code	Description
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, 8MG, 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
	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
Not Otherwise Classified (NOC)	
ICD-9 Codes that Support Medical Necessity	Not specified.
Diagnoses that Support Medical Necessity	Not specified.
ICD-9 Codes that DO NOT Support Medical Necessity	Not specified.
Non-Medical Necessity ICD-9 Codes Asterisk Explanation	
Diagnoses that DO NOT Support Medical Necessity	Not specified.
Reasons for Denials	Items listed in this policy will be denied as not medically necessary when provided for conditions other than those listed in the "Indications and Limitations of Coverage and/or Medical Necessity" section unless it specifically states in that section that they will be denied as noncovered.
Non-covered ICD-9 Codes	
Non-covered Diagnoses	Not specified.
Coding Guidelines	Codes Q0163-Q0181 may be billed only when the oral antiemetic drug is used in the situations described in Coverage and Payment Rules section. The quantity of drugs billed using codes Q0163-Q0181 must not exceed the 24 or 48 hours of therapy specified above.

	Code Q0181 is a miscellaneous code which may be used only when all the requirements of the policy are met, but the drug administered does not have a specific code (Q0163-Q0180). Refer to the Oral Anticancer Drugs policy for information on coding antiemetic drugs used in conjunction with oral anticancer drugs. Suppliers should contact the Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) for guidance on the correct coding of these items.
General Information	
Documentation Requirements	Section 1833(e) of the Social Security Act precludes payment to any provider of services unless "there has been furnished such information as may be necessary in order to determine the amounts due such provider" (42 U.S.C. section 13951(e)). It is expected that the patient's medical records will reflect the need for the care provided. The patient's medical records include the physician's office records, hospital records, nursing home records, home health agency records, records from other healthcare professionals and test reports. This documentation must be available to the DMERC upon request. An order for each item billed must be signed and dated by the treating physician, kept on file by the supplier, and made available to the DMERC upon request. Items billed to the DMERC before a signed and dated order has been received by the supplier must be submitted with an EY modifier added to each affected HCPCS code. The supplier must enter an ICD-9 diagnosis code corresponding to the patient's cancer diagnosis on each claim. Claims for code Q0181 must be accompanied by the name of the drug, the manufacturer, the dosage strength dispensed, the number of tablets and frequency of administration during the covered time period (24-48 hours) as specified on the order. This information should be entered in the narrative field of an electronic claim or attached to a hard copy claim. Refer to the Supplier Manual for more information on documentation requirements.
Appendices	
Footnotes	
Utilization Guidelines	Refer to Indications and Limitations of Coverage and/or Medical Necessity.
Other Comments	
Sources of Information and Basis for Decision	Reserved for future use.
Advisory Committee Meeting Notes	
Start Date of Comment Period	
End Date of Comment Period	
Start Date of Notice Period	09/01/1999
Revision History Number	OEMT003

Revision History Explanation	Revision effective date: 07/01/2003 INDICATIONS AND LIMITATIONS OF COVERAGE: Corrects reference to immunosuppressive drugs which should be oral antiemetic drugs. Revision effective date: 04/01/2003 HCPCS CODES AND MODIFIERS: Added: EY modifier INDICATIONS AND LIMITATIONS OF COVERAGE: Adds standard language concerning coverage of items without an order DOCUMENTATION REQUIREMENTS: Adds standard language concerning use of EY modifier for items without an order The revision date listed below is the date the revision was published and not necessarily the effective date for the revision. 04/01/2001 - The revision language reflects a change in jurisdiction for claim submission by physicians who are also DMEPOS suppliers. In addition, the policy incorporates instructions from the Centers for Medicare & Medicaid Services (CMS), formerly the Health Care Financing Administration, regarding entities qualified to dispense and bill for Medicare-covered drugs.
Disclaimer Specialty Name	
LMRP Attachments	There are no attachments for this LMRP

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