Historic Changes to Medicare Will Affect Cancer Programs

Signed into law by President Bush on Dec. 8, 2003, the Medicare legislation is the culmination of six years of work to revamp the current Medicare program and put in place a prescription drug benefit for seniors. Said by some to be the most significant vote cast by Congress in the last two generations, this new law will affect millions of seniors today and well into the future. While this new law will cost the federal government about $400 billion over the next 10 years, the price tag is expected to escalate into the trillions sometime after those 10 years.

The provisions drawing the most publicity in this law surround the creation of a new prescription drug benefit. Starting in 2006, patients could obtain that coverage by buying a separate private insurance policy for drugs or by joining a preferred provider organization (PPO), HMO, or other type of private health plan that also provided the rest of their care.

In either case, the coverage would require patients to pay a monthly premium averaging $35 the first year, and a $250 annual deductible. After the premium and deductible are paid, the government would pay three-fourths of the patient's drug expenditures up to $2,250. At that point, the coverage would stop, except for a relatively small number of people with "catastrophic" drug expenses who have paid at least $3,600 a year from their own pockets. Because the monthly premiums and deductibles are tied to the expected growth in drug expenditures, seniors will pay considerably higher premiums and deductibles in subsequent years.

Provisions Affecting Cancer Care

The new law also includes numerous provisions that will affect cancer care delivery in the coming years for both hospitals and oncology practices. Congressional Budget Office (CBO) scoring indicates that moving to the competitive acquisition of covered outpatient drugs will "save" the government $4.2 billion over the next 10 years. Because most of these drugs are cancer drugs, this $4.2 billion "savings" will have a dramatically negative effect on the specialties of oncology, medical oncology, and hematology/oncology. Although a breakdown of the $4.2 billion shows an initial increase of $100 million in 2004, subsequent decreases are alarming: a decrease of $100 million in 2005, and subsequent annual decreases of $200 million and $300 million, respectively. Increases in administration payments may offset some of these reductions.

Here's how hospital outpatient oncology programs will be affected.

Payment floors and ceilings. Payments for some sole-source drugs were as low as 50 to 60 percent of average wholesale price (AWP) in 2003. Now, sole-source drugs cannot be reimbursed less than 88 percent of AWP in 2004 and no less than 83 percent in 2005. Innovator multiple-source drugs and non-innovator multiple-source drugs have payment ceilings of 68 percent and 46 percent of AWP, respectively. This provision addresses the fact that some drugs in these two categories were paid a greater percentage of AWP than some sole-source drugs in 2003.

Radiopharmaceuticals are to be treated like all other covered outpatient drugs for purposes of these payment floors. In 2006 and beyond, drugs will be reimbursed the "average acquisition cost," an amount to be determined by the HHS Secretary, taking into account two General Accounting Office (GAO) hospital acquisition cost surveys. If hospital acquisition cost data are not available, payment would be based on the physician-office payment level.

Pass-through drugs. For drugs that were on the pass-through before April 1, 2003, the 2004 payment will be 85 percent of AWP, based on the physician-office payment level. For drugs that were on the pass-through on or after April 1, 2003, the 2004 payment will be 95 percent of AWP. (Please note that during this same year, sole-source drugs that have rolled off the pass-through will be paid at 88 percent of AWP.) Starting in 2005, all drugs on the pass-through will be paid at average sales price (ASP) plus 6 percent. In 2006 and beyond, these same drugs will be paid at ASP plus 6 percent *or* under the competitive bidding system. However, radiopharmaceuticals are exempt from the competitive bidding system.

Drug acquisition cost surveys. A survey will be conducted by the

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GAO in 2004 and 2005 and submitted to the HHS Secretary no later than April 1, 2005, for use in setting rates for 2006. In addition, the Medicare Payment Advisory Commission (MedPAC) must submit a report to the HHS Secretary no later than July 1, 2005, regarding overhead and related costs, "such as pharmacy services and handling costs."

Unbundling. While the legislation called for drugs above $50/encounter to be unbundled from their administration payment starting in 2005, the final hospital outpatient prospective payment system (OPPS) rule released by the Centers for Medicare & Medicaid Services calls for unbundling at $50/day starting in 2004. Since the legislation and regulatory provisions aren't contradictory, ACCC expects CMS to implement both in the interim final rule.

New drugs without a C-code will be paid at 95 percent of AWP.

Devices of brachytherapy (seeds) will be reimbursed at "charges adjusted to cost" in 2004 through 2006. The GAO will submit a report to Congress no later than Jan. 1, 2005, regarding appropriate payment amounts for brachytherapy.

Functional equivalence is not to be applied in the future.

And in Physician Offices...

Under the new Medicare bill, compensation to oncology practices will be changed, but the degree of that reimbursement change remains unclear.

Oncology practices across the country have been barraged with emails and faxes offering different and definitive interpretations of the dire impact of the Medicare bill on their practices. The fact is that, as of Dec. 24, 2003, we just do not yet know the impact of the bill on oncology practices. Compensation to oncology offices will be changed according to elaborate Congressional language that is complex (some would say unfathomable) and requires CMS interpretation. That interpretation will not be forthcoming until the final rule is announced and implemented. Some analysts have suggested that oncologists may end up with a $100 million boost in 2004, when the practice expense additions are factored in.

That's not to say that the implications for 2005 and 2006 aren't dramatic and not good for oncology practices. Still, the panic in the streets concerning what will happen Jan. 1, 2004 is just that: panic. Recently, various "analysts" have come out with lists of drugs that practices should abandon and types of patients who are no longer "good" to see in the office setting. All of this is before a definitive rule from CMS is released that details the real reimbursement of drugs or the kind of compensation that practices will be receiving for administration of these drugs. In other words, a lot of rumors and guesswork are circulating. Much of this information is fear-based; little of it is fact-based.

Oncology practices need to take a deep breath (several would be good) and, while continuing to breathe, wait until CMS releases its final regulations. We will have a definitive read. The rule may be terrible, or it may not. Although we may have just a few days to adjust, there is at least an equal chance that we'll have another year to take appropriate action and fix the problems.

In 2004 drug payments in physician offices will be reduced to 85 percent of AWP for most products. Some drugs will have a payment floor of 80 percent, which will be based on an average of data obtained from the Office of the Inspector General (OIG) and the GAO.

Drug administration payment will increase. Early estimates put drug administration payment increases at $500 million. CBO initially estimated that this increase would result from:

- Use of the Gallup survey data
- Adding work values into chemotherapy administration (equivalent to a Level 1 office visit for an established patient)
- A 32 percent increase in physician fee schedule payment for drug administration services
- Payment for multiple pushes.

In 2005 drug payments would shift to ASP plus 6 percent. However, the HHS Secretary would have the discretion to use wholesalers' acquisition cost (WAC) instead. At press time, estimates put the practice expense increase at no more than $380 million in 2005 and $340 million in 2006. This reduction is due, in part, to a reduction in the 32 percent transitional increase in drug administration payments to no more than 3 percent in 2005.

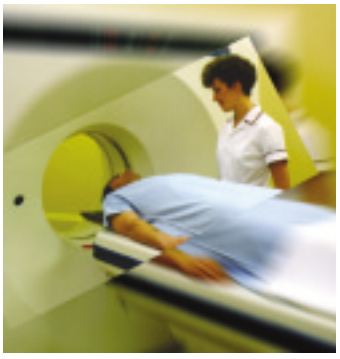
A new practice expense survey could be conducted and submitted to CMS no later than March 1, 2004. If submitted, its results could extend the budget neutrality exemption (thus adding new dollars again) into 2005. If no such additional survey is undertaken, the existing Gallup survey would be used in 2005, but not in a budget neutral way. The same process would apply for 2006, with surveys due to CMS no later than March 1, 2005.

In 2006 physicians would have a choice between purchasing drugs and being paid at ASP plus 6 percent *or* obtaining them through a competitive acquisition program contractor. Radiopharmaceuticals would not be subject to competitive bidding.

Final OPPS Rule: Major Changes to Radiation Oncology

Radiation oncology experienced major payment cuts under the changes to the final OPPS rule that took effect Jan. 1, 2004. Here's what happened.

CMS decreased payments by 29 percent for external beam treatment delivery in ambulatory payment classification (APC) 301 from $165 to $116.



The agency decreased payments for IMRT delivery 26 percent from $400 to $294. Based on median costs, CMS also moved this procedure

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from a new technology APC to a regular APC. After public comment, CMS kept IMRT planning in a new technology APC with a payment of $850. Originally, CMS proposed reducing the payment from $875 to $328 (a 63 percent drop) and moving the procedure from a new technology APC to a regular APC based on median costs.

CMS decreased payment for high dose rate brachytherapy by 19 percent, which brought the new payment to $887. Initially, CMS proposed to reduce payment 35 percent ($1,097 to $713).

The agency now permits separate payments for radioactive sources/seeds in low dose rate brachytherapy and prostate brachytherapy. Although CMS listed payment rates for seeds, the new Medicare law mandates that "devices of brachytherapy" (seeds) will be reimbursed at "charges adjusted to cost" in 2004 through 2006. The GAO will submit a report to Congress no later than Jan. 1, 2005, regarding appropriate payment amounts for brachytherapy.

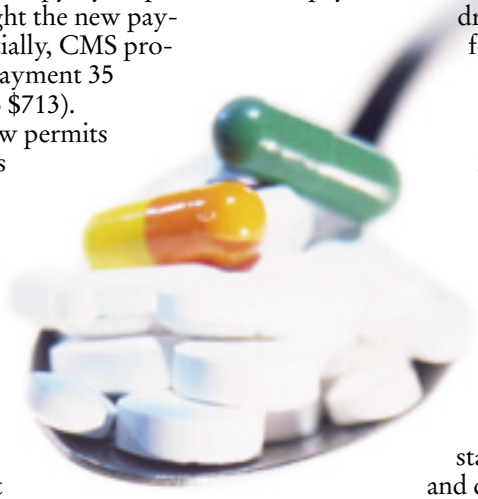
In the final rule, CMS listed payment for APC 312 at $200 and APC 651 at $545.

For prostate brachytherapy, CMS discontinued the use of codes G0256 and G0261 and APCs 649 and 684, and, as stated above, will now pay separately for sources/seeds. In addition, CMS assigned HCPC code 55859 to APC 163 (Level IV Cystoscopy and other Genitourinary Procedures) with a payment of $1,849. CMS assigned HCPC code 77778 to APC 651 (Complex Interstitial Radiation Source Application) with a payment of $558.

Oral Anticancer Demonstration Project Included in Medicare Law

A provision in the new Medicare law provides the structure for a demonstration project to investigate the benefits of altering the current oral anticancer drug payment system under Medicare.

Currently, reimbursed oral anticancer medications must be administered "incident to" a provider's service and they must have an injectable counterpart. Many new anticancer drugs are made exclusively in oral form and an injectable counterpart is not available. Because Medicare does not pay for these oral anticancer drugs, providers are forced to look for alternative therapies that are reimbursed. Many times, patients must undergo injectable anticancer therapies that take more time to administer, require additional medical staff to monitor, and do not allow the patient to benefit from new drug formulas that may reduce side effects.



The demonstration project would allow reimbursement for oral anticancer drugs that have no injectable counterpart in an effort to investigate the cost savings of reduced physician and outpatient administration services. The two-year demonstration project for oral anti-cancer drugs would span 50,000 patients in six states. This project was allocated $500 million.

A report would be submitted to Congress by January 2006 outlining the effectiveness of oral anticancer therapies on patient access to care, patient outcomes, and cost effectiveness of the program.

Congress has made previous attempts to include coverage for oral anticancer drugs under Medicare. This demonstration project is the culmination of work by Senator Olympia Snowe (R-Mass.) and Representative Deborah Pryce (R-Ohio) to highlight this reimbursement issue with the introduction earlier this year of the "Access to Cancer Therapies Act of 2003." This legislation proposed to extend Medicare reimbursement to all oral anticancer drugs regardless of the availability of an injectable counterpart.

Medicare to Cover Fecal-Occult Blood Tests

Based on a technology assessment that CMS requested from the Agency for Healthcare Research and Quality (AHRQ), and after consultation with appropriate organizations as required by Medicare law, CMS has decided to provide annual coverage of the screening iFOBT as an alternative to (or substitute for) the screening guaiac fecal-occult blood test (gFOBT), for all beneficiaries age 50 and older.

The immunoassay test requires the collection of fewer specimens than the guiaic test and does not require any dietary restrictions.

Colorectal cancer (CRC) is the fourth most common cancer in men and women the U.S., and the second leading cause of cancer mortality. Scientific studies have shown that early detection and treatment can have a major impact on mortality from CRC.

CMS Survey Finds 5.8 Percent of Medicare Claims Had Incorrect Payments

CMS' expanded and newly detailed survey of recently paid Medicare claims showed that 5.8 percent of the claims has errors, representing $11.6 billion in incorrect payments. These figures, however, represent a

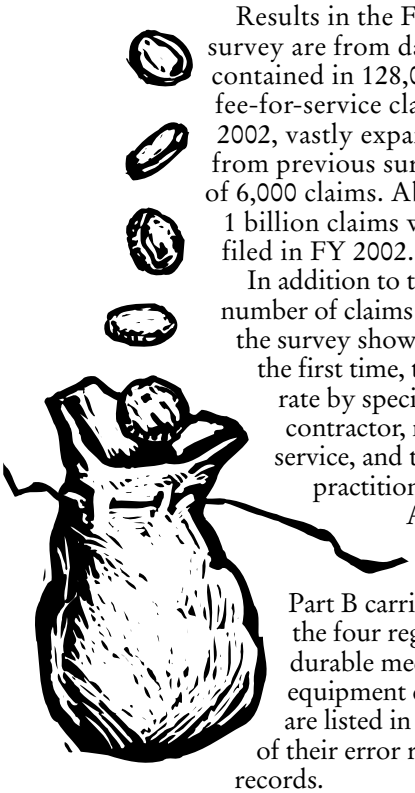
decrease compared to FY 2002.

Chiropractors, physical therapists, and internists, for example, had the most errors, while ambulance services, podiatrists, hematologists/oncologists, and urologists were among those providers that had the least, according to the report. (See *http://www.cms.gov/providers/psc/cert.asp*).

Regarding improper claims, the report found that 45 percent of the national paid claim error rate was due to insufficient documentation; nearly 22 percent was attributed to medically unnecessary services; and 12 percent was attributed to incorrect coding.

The new findings represent an expanded effort to measure improper payments compared to previous years. The agency's goal "is to bring about a dramatic reduction in the Medicare payment errors in the next 24 months."

The agency said it will focus on contractors and providers with particularly high error rates and will work to educate healthcare providers on the proper coding and documentation of medical procedures. Other attempts will include the development of a computerized tool that generates state-specific hospital billing reports to help quality improvement organizations analyze claims data.



Results in the FY 2003 survey are from data contained in 128,000 fee-for-service claims in 2002, vastly expanded from previous surveys of 6,000 claims. About 1 billion claims were filed in FY 2002.

In addition to the larger number of claims studied, the survey shows, for the first time, the error rate by specific CMS contractor, medical service, and type of practitioner.

About two dozen Part B carriers and the four regional durable medical equipment carriers are listed in order of their error rate records.

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NCI Awards Grants on Aging and Cancer

The National Cancer Institute (NCI) and the National Institute on Aging (NIA) are launching a new initiative to accelerate research into the relationship between aging and cancer. The five-year approximately $25 million grant program will begin with $5 million in first-year grants to eight research centers.

Four of these academic centers are ACCC-member institutions that have been selected to receive grants in the first year of the project. They are the H. Lee Moffitt Cancer Center in Tampa, Fla., awarded a $519,000 grant; the University of Colorado, in Denver, awarded a grant of $653,000; the University of Pittsburgh Cancer Institute in Pittsburgh, Pa., awarded a $652,000 grant; and the University of Wisconsin in Madison, awarded a grant of $586,000.

At the H. Lee Moffitt Cancer Center, Paul Jacobsen, PhD, will lead the study. Moffitt Cancer Center funds will support planning and educational activities in five thematic areas: 1) palliative care, end-of-life care, and pain relief; 2) psychosocial issues and medical effects; 3) biology of aging and cancer; 4) effects of comorbidity; and 5) treatment efficacy and tolerance. In addition, funds will be used to support a shared resource in health outcomes measurement that will be used by investigators conducting aging and cancer research.

At the University of Colorado, Tim Byers, MD, will lead the project, which will feature education within the cancer center and community; career development of scientists and academic clinicians in aging and cancer research; and the development of innovative pilot projects designed to lead to collaborative research in the etiology, prevention, and management of cancer in older patients. All seven thematic areas will ultimately be addressed through these mechanisms.

At the University of Pittsburgh Cancer Institute, Ronald Herberman, MD, director of UPCI, will serve as the principal investigator of the project. UPCI will perform pilot research studies focusing on the immunobiology of cancer in elderly patients; develop, test, and disseminate aging-relevant measures of comorbidity, functioning, and outcomes; and develop appropriate interventions for older people with cancer. Focus areas will include clinical trials of treatment efficacy and tolerance, behavioral and social issues in older cancer patients, and the biology of aging.

At the University of Wisconsin, Richard Weindruch, PhD, will be principal investigator of the project. UW-Madison will address knowledge gaps in five thematic areas, including palliative care, patterns of care, effects of comorbidity, psychological issues, and biology of aging. An aging/cancer mouse model resource and a laboratory to evaluate comorbidity factors will also be developed.

The other four academic centers selected to participate in the five-year grant program are Case Western Reserve University in Cleveland, Ohio; Memorial Sloan-Kettering Institute in New York City; the University of Iowa in Iowa City, Iowa; and the University of Washington, in Seattle, Wash.

Ready or Not— Here Come JCAHO's

For years advocates have urged that the Joint Commission on Accreditation of Healthcare Organizations' (JCAHO) visits should be unannounced. Supporters say such visits would stop last minute scrambling by hospitals to put policies and procedures in place, complete patient records, and ensure that the facility is bright and shiny. Unannounced visits send the message that hospitals should *always* be operating in full compliance with JCAHO standards and provide high-quality patient care.

The pragmatic implications of unannounced visits raise some important practical issues, and for the process to work fairly, providers need to know how JCAHO plans to deal with these issues. In 2004-2005, JCAHO will pilot the unannounced visit program, testing it in 100 facilities that have volunteered to help.

Linda Murphy-Knoll, RN, MN, vice president, Accreditation Service Operations, is responsible for JCAHO's unannounced survey project. Here are her responses to questions on the practical implications of this program change.

Q. How will a hospital gather all the required information if the JCAHO survey is unannounced?
Traditionally, assembling the information required for JCAHO surveys meant a monumental effort by the Health Information Management (HIM) department of the hospital. Statistics on incomplete records must be gathered and summarized, documentation audits must be prepared, and quality-monitoring studies must be conducted. The review team arrives with lists of charts to be pulled for record review. The HIM staff must then print out listings from abstracting systems or other data sources, pull records, and provide them to the JCAHO reviewers. For a typical 200-bed hospital, these activities translate into four to six hours of HIM staff time.

A. JCAHO is moving away from surveys focused on documentation reviews and formal presentations.

JCAHO's Shared Vision-New Pathway survey process will review the actual processes surrounding patient care. Approximately 60 percent of the survey time will be spent following selected patients (called "tracers") through their care process on nursing units and in ancillary departments. The surveyors will ask various caregivers questions about how they perform patient care processes, patient education, and how they provide safe care. The surveyors will integrate administrative reviews such as credentialing and use of data throughout the process as they relate to care delivery. Staff may be asked how they use information as it relates to patient care. For example, staff could be asked what they do to protect their patients from infections.

Q. What about scheduling conflicts? What if an unannounced visit coincides with other major hospital events?
How would JCAHO reviewers conduct an accreditation visit if a facility were opening a new wing, a new facility, or a new HIM department? Would such a review truly reflect facility operations?

What if a facility is undergoing a computer conversion or installation of a new clinical or administrative computer system? Although manual processes would be put in place during the "switch over" from one system to another, not all administrative computer functions would be immediately operational. In such an instance, pulling a list of patient records for a chart review or providing any statistics or summary reports would be nearly impossible. Re-establishing an incomplete chart system or an abstract database would not take priority over getting lab and ordering systems up and running. How will this type of scenario be handled and will the visit accurately reflect the facility's operational quality and capabilities?

A. Finding ways to deal with such issues is exactly why JCAHO is piloting the program during 2004 and 2005. JCAHO plans to test the unannounced survey process in about 100 facilities that have volunteered to help with this project. JCAHO is currently planning to allow "black-out" dates, which are windows during which facilities do *not* want a survey scheduled. At present, JCAHO believes that 10 "black-out" dates will suffice, but that number could change.

Q. What about survey visits that are now coordinated with other entities?
What will happen to those programs in which state surveyors conduct their facility reviews in conjunction with a JCAHO review (e.g., a CALS survey in California)? Do unannounced JCAHO visits mean the facility will need to go through two separate surveys, thereby increasing review costs and overhead?

A. JCAHO is working with agencies in California to try to maintain a coordinated process, which will be included in the pilot testing.

Q. Will JCAHO still allow integrated delivery networks and other multi-facility organizations to

[Unannounced] Visits

by Cheryl Servais, MPH, RHIA

schedule their surveys sequentially in advance?
How would a corporate support team be able to work with the JCAHO team? In the past, this option has been a welcome courtesy for healthcare systems.

A. JCAHO has formed a Corporate Users Group to formulate suggestions on how to best handle the unannounced survey process in multi-facility networks. One thought is to have the same JCAHO team leader review all the facilities for an organization and then provide a summary to corporate representatives.

Q. How does a facility "plan" for the unannounced survey?
How should a facility handle vacations, management retreats, or out-of-town conferences that mandate attendance by key staff? Would it be ideal to conduct a survey without the CEO, CNO, chief of the medical staff, department chairmen, or the director of HIM services? While larger facilities might be able to "fill-in" for absent staff, smaller facilities may not be able to do so. One option: hiring consultants to be available whenever a staff member went on vacation or left for a seminar would definitely increase the cost of healthcare.

A. The "black-out" dates discussed above will allow facilities to plan management retreats or conferences.

Other issues such as vacations and time off from work will be addressed during the pilot phase. Because the new survey will focus on direct patient care, surveyors will be spending most of their time asking questions of staff who work directly with patients rather than with a facility's administrative team.

Q. How will a facility plan and schedule functions that tie up conference rooms, an auditorium or meeting space, and other special events?

A. Because the survey process will concentrate on patient care events, the need for large conference rooms and formal presentations will be greatly reduced.

Q. Is an unannounced survey really a surprise?
In the real world, several factors may prevent these unannounced visits from being a true "surprise."

Most HIM professionals belong to one or more online discussion lists that share information about accreditation teams and survey processes. In the past, JCAHO has sent a review team to a city to conduct reviews at several facilities over the same time period, saving transportation costs for JCAHO.

Under the unannounced visit plan, the first facility surveyed might be truly "surprised," but word would quickly travel that the JCAHO team was in town. Other facilities would have some advance warning. Even a few days notice might make a difference in the outcome of the visit.

A. JCAHO is reviewing its scheduling process to make it as random as possible.

Q. But won't those hospitals visited during the first part of the calendar year be more "surprised" than those reviewed later in the year?
As the year progresses, a hospital will be more and more certain of when the accreditation team will arrive and could press to improve normal operations. Would facilities surveyed in December have an advantage over those reviewed in January?

A. JCAHO feels not knowing the date of the review will ensure that the facility is always "survey ready" and in compliance with standards. Facilities surveyed in December will operate year round as if they were going to be surveyed and have no need for last-minute improvements. In addition, random unannounced surveys will continue to be a part of the JCAHO review program at least through 2008. These surveys can occur during the nonreview years for a facility. A facility scheduled for review in 2007 could have a random unannounced survey in 2006 or 2008. For that reason, facilities will always need to operate as if a survey were imminent.

From a patient-care perspective, unannounced surveys by JCAHO provide a true rating of a facility's ability to provide quality healthcare. The purpose of unannounced surveys is to "catch" facilities performing as they do every day—not in a heightened state of readiness. JCAHO is piloting the unannounced survey process in an effort to address issues that could arise and to make the process fair for all providers. Any facility interested in volunteering for an unannounced survey or anyone with a concern about the survey process should contact their JCAHO account representative.

Cheryl Servais, MPH, RHIA, is vice president, compliance and privacy officer for Precyse Solutions, Inc., in King of Prussia, Pa.

Coding for Hospital Outpatient Infusion Services in 2004

by Linda B. Gledhill, MHA

PHOTOGRAPH/BRANDXPICTURES.COM

Effective Jan. 1, 2004, new coding guidelines for hospital outpatient services will be implemented under the revised final outpatient prospective payment system (OPPS) rule issued by the Centers for Medicare & Medicaid Services. A significant change in the 2004 coding guidelines includes a simplification of the Q-codes for chemotherapy and therapeutic infusion.

Q *Has code Q0085 been eliminated? How should you code chemotherapy by infusion and other methods, such as a push?*

A Q0085 has always been difficult to code and is not used very often, so in 2004 CMS eliminated this code. The rule states that if chemotherapy IV infusion *only* is provided, Q0084 should be used. If, in addition to the IV infusion, another form of chemotherapy administration (e.g., subcutaneous, intramuscular, or a push) is provided, you can also charge code Q0083. Although in the past CMS followed a "one Q-code per day" rule, CMS has clearly stated that both codes will now be accepted. Both providers and payers will need some time to get used to this change, so closely watch how you code and your subsequent reimbursement.

Q *With all of the cancer drugs being packaged into the administration codes, will this change help cover the cost of providing the infusion and drugs?*

A In 2003, CMS packaged many chemotherapy and supportive care drugs into the administration codes. The payments for all drugs costing $150 or less per day were bundled into their administration codes. After much discussion and public comments, CMS revised that threshold for 2004. Starting Jan. 1, only drugs costing less than $50 per day are bundled into their administration codes. CMS maintains that lowering the threshold will result in appropriate payment for both the procedure and the drug.

Here is a list of some cancer drugs, their HCPCS code, and their Medicare reimbursement in 2004.

- Granisetron, 100 mcg (J1626): $5.70
- Sargramostim, 50 mcg (J2820): $16.32
- Doxorubicin, 10 mg (J9000): $6.61
- Etoposide, 10 mg (J9181): $4.56.

Q *Should we continue to bill drugs that are still packaged into their administration codes?*

A Yes. Reporting the cost of those packaged drugs to CMS is very important, because the data are used to determine your actual costs for that service. Without this data, CMS does not really know what is required to cover the cost of the infusion and drugs administered. You should continue to use revenue code 636 for drugs in addition to the appropriate HCPCS code for drugs that have a separate payment. Use any of the other drug revenue codes for packaged drugs billed to CMS. The costs reported for packaged drugs are also used by CMS to calculate outlier payments.

Q *When using codes 90782, 90783, and 90784 for injections, how do you code for multiple injections given on the same day?*

A In 2004, you should bill the therapeutic injection codes: 90782 (subcutaneous/intramuscular), 90783 (intra-arterial), and 90784 (intravenous) each time there is a separate injection. Use the unit column to indicate multiple injections during a visit.

Q *Why does the code for hydration prior to chemotherapy (Q0081) receive so many claim denials, and has this code changed in the new rule?*

A Q0081 has not changed for 2004. If there is medical necessity for hydrating a patient prior to chemotherapy, CMS states Q0081 should be a payable code *as long as* the hydration is given sequentially and not at the same time as the chemotherapy. Since the hydration is a separate procedure on the same day, however, the code requires a -59 modifier. You must also document the beginning and ending time for each procedure to show that the procedure was sequential.

Q *Has there been any change in payment for transfusions in 2004?*

A CMS has frozen the reimbursement of blood and blood products at 2003 payment rates. The agency cites the additional cost of testing the blood supply and other concerns as the primary reason. CMS will conduct more studies to determine if the payment rate should change in 2005.

The OPPS final rule is available on the CMS website at *www.cms.gov.*

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