ISSUES THE

Weathering Hurricanes Frances and Jeanne

The mission of community cancer centers takes on new meaning during a natural disaster.

In 2004 within a six week period, an unprecedented four hurricanes—Charley, Frances, Ivan, and Jeanne—hit Florida. Not since 1886 has one state been battered by four hurricanes in one season. One ACCC-member institution was hit particularly hard: Martin Memorial Health System in Stuart, Fla.

Most of Martin Memorial Health System's campus is located on the beautiful St. Lucie River that feeds into the nearby Atlantic Ocean. A separate Hospital South is located 20 minutes away from the main campus.

In preparation for the arrival of Hurricane Frances, mandatory Management Briefing Sessions had already begun at Martin Memorial. One priority was to discharge or transfer patients to a variety of Florida hospitals located far from the coastline. The oncology inpatient unit discharged or transferred about 20 patients. Then, the hurricane "A" list of staff who would work during the storm was notified of where to report and what to bring, including water, food, and bedding in preparation for being locked down at the hospital. Schools were already closed, and Martin Memorial started a day care center for children of those employees who would be locked down at the hospital during the storm.

On Labor Day weekend 2004, Hurricane Frances made landfall near Stuart as a category 2 hurricane, with 105 mph winds. While Martin Memorial Cancer Center was largely spared Frances' rage, Memorial Health System's North Hospital was hit hard. Elevator shaft damage on the roof meant floors two through six were inaccessible and patients had to be carried down the stairs to the main floor. The inpatient oncology unit at North was not operational, and the cancer center stepped up to meet the need. The outpatient cancer center infusion suite began operating after hours and on weekends to meet the needs of patients.

"Accommodation and scheduling were the key," said Debbie Lewandowski, RN, BSN, OCN®, director of oncology services. "My infusion staff stepped up to the plate and helped prepare a schedule to make this work. They were also affected by the storm, but knew how important infusion care was to our community. My infusion staff took leadership roles in making sure that patients' needs were being met."

Approximately three weeks after Hurricane Frances came ashore, Hurricane Jeanne arrived. Jeanne was a faster, more devastating storm. This time Martin Memorial's state-of-the-art 41,000-square-foot cancer center took a heavy hit: major water intrusion, carpets ruined, walls demolished, windows broken, and ceilings damaged. And, of course, no electricity.

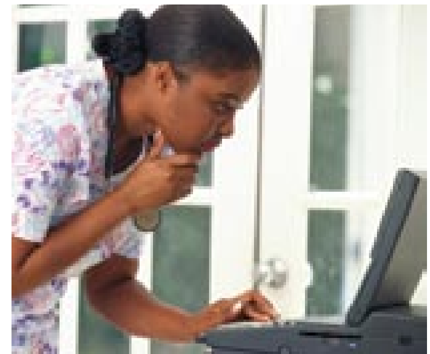
When the extent of the storm's damage was assessed, it became clear that the cancer center would not be operational for weeks. In addition, many private oncology practices in the cancer center were without functional office space in the storm's aftermath. Martin Memorial Hospital welcomed them into the hospital system and found temporary work space. Everyone shared the same goal: uninterrupted patient care.

From the post-hurricane vantage point, by New Year 2005 things are getting back to normal at Martin Memorial. The Disaster Resource Center assisted more than 600 fellow associates, and generous donations from the Associate Relief Fund totaled $180,000. Martin Family Connections, headed by the Human Resources Department, matched associates who had housing needs with associates who could provide assistance. The relief efforts provided hundreds of staff with the ability to continue working and to begin putting the pieces of their lives back together. Oncology has united on many fronts, and this truly was a tribute to all working together and connecting, said Lewandowski. OI

The north elevator tower of Martin Memorial Medical Center was damaged during Hurricane Frances in Sept. 2004, limiting access to floors two through six.

Following Hurricane Frances and Hurricane Jeanne, Disaster Medical Assistance Teams set up operations in the parking lot of Martin Memorial Health South. The teams served emergency patients.

PHOTOGRAPHS COURTESY OF LISA HORNAMAN AT MARTIN MEMORIAL HEALTH SYSTEM


PHOTOGRAPH/CREATAS

Using the New G-codes

by Linda B. Gledhill, MHA

In the final physician rule published in the Federal Register on Nov. 15, 2004, the Centers for Medicare & Medicaid Services (CMS) announced that it would begin using G-codes in 2005 for the administration of chemotherapy, hydration, and administration of supportive care drugs. The G-codes are temporary and will be given CPT codes in 2006.

In addition to the new administration codes, CMS also announced a one-year demonstration project to evaluate the resource consumption associated with evaluation of pain, nausea and vomiting, and fatigue associated with chemotherapy services provided in an office-based practice.

Now that practices have had several months to work with these new codes, here are answers to some commonly asked questions about how to use them.

Q *Many times I give patients more than one antiemetic for nausea. Can I charge for more than one infusion?*

A: Yes. When a patient receives more than one antiemetic infusion, use G0349. This code is used to report the first hour of a "sequential infusion of a second non-chemotherapy drug."

Q *Which of the hydration codes should be used when I hydrate a patient concurrently with chemotherapy?*

A: You can now use the code G0346 for concurrent IV infusion. Use this code with a primary code of G0359.

Q *CMS is now paying non-chemotherapy therapeutic injections. If I provide another service on the same day, will these injections be paid or will they be considered to be part of the other service?*

A: These services will now be paid in addition to the other services provided.

Q *G0356 is used to bill for antineoplastic hormonal injection therapy. Can you give me an example of which drugs these refer to?*

A: In 2005 CMS added two new codes for subcutaneous or intramuscular hormonal and non-hormonal antineoplastic injections. These are G0355 for chemotherapy injection, non-hormonal antineoplastic; and G0356 for hormonal antineoplastic injection. Two of the most frequently used hormonal antineoplastic drugs are leuprolide acetate and goserelin acetate.

Q *In order to bill for an E&M code on the same day as chemotherapy, do I need to have a different diagnosis code for the visit?*

A: No. The E&M service has to be provided as a significant separately identifiable service and the -25 modifier attached. A different diagnosis code is not required for this visit.

Q *Can I bill for flushing a port, G0363, on the days that a patient is receiving chemotherapy?*

A: According to CMS, a port flush is a billable service only on the days where no other services are provided.

Q *CMS has expanded its list of drugs that can be used with the chemotherapy administration code. One category mentioned is monoclonal antibodies. How can I tell which drugs are considered monoclonal antibodies?*

A: Drugs that end in "–mab" are generally included in this category. Examples would include trastuzumab, infliximab, rituximab, gemtuzumab, and alemtuzumab.

Q *CMS refers to some of the new G-codes as add-on codes. What does this mean and how does it work?*

A: CMS defines add-on codes as codes that are used in addition to a primary code. CMS will pay for these services only when they are billed along with a primary drug administration code. An example would be G0346, IV infusion, hydration, each additional hour up to 8 hours. This code would not be billed alone but would require G0345, IV infusion, hydration initial hour.

Q *I have reviewed the third-quarter drug reimbursement on the CMS web site. Will this reimbursement be the same for all of 2005?*

A: No. The new ASP drug payment system is based on quarterly data submitted to CMS by manufacturers. The rates in the physician practice will be adjusted quarterly and may fluctuate.

Q *If we do a patient evaluation under the demonstration project and do not complete the section involving pain, can we charge for the assessment of nausea/vomiting and the assessment of fatigue?*

A: No. According to CMS, transmittal 12, no payment will be made for the demonstration codes unless all three codes are reported.

Q *When we charge for the assessment under the demonstration project, is the patient responsible for a co-payment on the $130 allowance?*

A: Yes, the patient is responsible for a co-payment of 20 percent. In addition, any deductible amounts also apply.

Linda Gledhill, MHA, is senior associate of Consulting Services at ELM Services, Inc., in Rockville, Md.