

**Medicare Tennessee CAC Meeting  
November 3, 2011  
4-6PM  
TMA Board Room, Nashville**

Colleagues,

I attended the Tennessee CAC meeting Thursday. Dr. Greg McKinney, Cahaba CMD, presided. During the meeting four LCD's were presented. Two were of relevance to Oncology practice.

- 1. Hydration Therapy. This LCD basically followed the preamble language from the AMA CPT manual. I do not believe that there will be any restrictions or changes related to the way that oncology practices code for hydration. Remember that hydration is only separately billable if it is required for volume expansion in a clinically dehydrated patient, if hydration is required to prevent toxicity from chemotherapeutic agents, for the treatment of hypotension, and for the management of clinical problems such as hypercalcemia. Having an IV running while other meds (including chemotherapy) are being administered is not considered hydration therapy. Fluid used to administer drugs is considered incidental hydration, and not separately billable. Less than 500 ml of fluid is not considered hydration therapy. Hydration therapy beyond 12 hours should have a legitimate medical reason that is carefully documented—simply continuing an IV in the outpatient setting, ED, or observation unit is not considered hydration.**
  
- 2. Circulating Tumor Cell (CTC) Assay. This LCD refers only to the CellSearch CTC assay (Veridex, LLC). Any other CTC method is not covered at this time. The CTC assay is restricted to patients with metastatic breast cancer, colorectal cancer, and prostate cancer. There is no coverage for CTC assay used in cancer screening. After patients are transitioned to hospice care, no further CTC assays will be covered. The LCD did established frequency parameters which I feel are unnecessarily restrictive, and if applied, make the testing less clinically relevant. Initial parameters limited testing to baseline, conclusion of therapy, and annual surveillance. I discussed the clinical utility of other methods of monitoring response to therapy, and suggested that if clinicians are using CTC assays to monitor patient response to therapy, more frequent determinations would be reasonable, at least every 2 or 3 cycles of therapy. Additionally, when monitoring patients off therapy I proposed that testing be covered every 4-6 months, rather than one year.**

I plan to submit written comments to Cahaba using the established mechanism via email. You may submit comments to [J10LCDComments@cahabagba.com](mailto:J10LCDComments@cahabagba.com)

**Updates were provided regarding RAC activity, the CERT program, and the OIG workplan.**

**The Tennessee CAC Co-Chair position has been vacant since Dr. McKay resigned last year. After discussion, and with prodding from other CAC members, I agreed to serve as the CAC Co-Chair for at least the next year.**

**The next Tennessee CAC meeting will be held in Nashville on March 1, 2012.**

**Respectfully submitted,**

**Charlie Penley, MD**